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Professional Development Implications for Counsellors Who Have Worked in The English Improving Access to Psychological Therapies (IAPT) Programme

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This Thesis has been completed as a requirement for a postgraduate research degree of the University of Chester

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I confirm that this Thesis is entirely my own work

DEDICATION

This Thesis is dedicated to my wife Bernardine Alice Mason – who has unconditionally supported and encouraged me personally, professionally, and academically throughout my studies.

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ABSTRACT

Background: Prior to the implementation of the IAPT programme by NHS England in 2008, counsellors were commonly employed to deliver psychological therapy in English NHS Primary Care Mental Health (PCMH) services. Pre-IAPT, professional development for PCMH practitioners, like the therapeutic approaches they offered, was non-standardised. Post-IAPT, PCMH provision became standardised, utilising manualised therapies alongside a commitment to outcome data completion. IAPT operates a highly structured approach to PCMH provision, arguably a treatment paradigm, in which ontological and epistemological entities are controlled. The model allows minimal flexibility in relation to what should, and how it should be treated; what data should, and how it should be gathered, and how outcomes should be interpreted. Clinical Commissioning Groups, contract to deliver IAPT services to any qualified providers, using IAPT data to determine performance. Arguably, IAPT has franchised PCMH in England. Professional development of IAPT practitioners is confined to training that supports the delivery of its aims. Consequently, service investment in training is focussed towards NICE approved approaches that are considered to be evidence-based. These approaches are epistemologically nomothetic, creating ideological challenges to counsellors who are epistemologically idiographic. This incommensurability between the IAPT treatment paradigm and counsellors, can affect professional development.

Objectives: This research focusses on implications for professional development of counsellors who have worked in IAPT. Conducted amongst ex-IAPT counsellors, to explore: the degree to which counsellors engage in IAPT professional development opportunities; how facilitative IAPT service is to professional development; how counsellors conceptualise and respond to those professional development opportunities.

Method: Semi-structured interviews of eight participants who had worked in different IAPT services across England were completed and analysed utilising an Applied Thematic Analysis.

Findings: Three themes were identified, exposing many implications for counsellor professional development, influenced by: *the IAPT Business and Clinical Models, and Participants Responses to those influences*, reflecting both external and internal ideological challenges towards professional development.

Conclusions: Ideological incommensurability, can result in both positive and negative professional development outcomes. Business and clinical models contributed to the struggle to identify, secure, or adapt to formal opportunities that are ideologically incompatible. However, participants capitalised on informal professional development opportunities. Exposure to the IAPT program, and the working environment of primary care mental health, enhanced knowledge and experience, administrative competence, and provided valuable exposure to wide-ranging variety of type and complexity in clinical presentation. This was identified as contributing to the development of a notable level of pluralistic practices. Participants did not disclose planned professional development strategies (appearing to respond intuitively to opportunity), suggesting that professional development was lacking intent. Therefore, counsellors are encouraged to reflect upon the type of psychological therapist they wish to become; contemplate the benefit of a structured professional development plan to achieve that aim; recognise the rich potential IAPT offers, and consider how IAPT might contribute to their professional development.

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Chapter 1: Introduction

1.1 Setting the Context

The Improving Access to Psychological Therapies (IAPT) programme has been NHS England's chosen model of primary care mental health (PCMH) provision for the last 12 years. The IAPT clinical model adopted the National Institute for Health and Clinical Excellence (NICE) guidance for the treatment of depression and anxiety disorders, replacing idiographic counselling approaches with nomothetic evidence-based approaches. This was not just about a change of process; it was about the process of change: personal ideological challenge to existing clinicians (many of whom were counsellors); managerial; organisational; and philosophical change. Counsellors employed in PCMH had careers, secure employment, salary, pensions, fraternity, professional esteem and were supported in their professional development aspirations. Counsellors are arguably vocationalists (Stoltenberg & Delworth, 1987; Ronnestad & Skovholt, 2003; Du Preez & Roos, 2008; Kern, 2014). Moss, Gibson, and Dollarhide (2014, p.3) for whom the advent of IAPT, dramatically affected employment circumstances. In the following 12 years, counselling has been, from the perspective of NHS England at least, invalidated. The consequent effect on the professional development of those counsellors, and counsellors who followed into IAPT has not been previously investigated. This research undertook to investigate that topic, using a qualitative thematic analysis, giving voice to the experiences of ex-IAPT counsellors, seeking to deliver a greater understanding of the limitations and opportunities that working as a counsellor in IAPT can offer. It presents a compelling narrative of personal experiences, serving to inform the reader of the geography of IAPT and how the counsellor might better navigate professional development within IAPT service, exploiting opportunity from a career perspective and/or capitalising on it post-IAPT.

1.2 Setting Out the Reason for the Research

IAPT has operated in the English National Health Service (NHS) since 2008 (DOH, 2008). IAPT is the model for PCMH provision offered by NHS England. It will be argued later that IAPT is a treatment paradigm. The concept of a paradigm – as opposed to the concept of an approach – is important. Paradigms are ontologically, and epistemologically controlled entities, according little flexibility in relation to opposing influences (Michell, 2000; Bryman, 2012, p.714; O'Reilly and Kiyimba, 2015, p.3). Counselling is ontologically and epistemologically, perhaps also ethically, opposed to the dictates, beliefs, values, and methods that underpin the IAPT programme. Although, others might argue that counselling was not intended to be included in the IAPT treatment paradigm. Bryman (2012, p.630) describes this feature of paradigms as being 'incommensurable'. Paradoxically, despite this incommensurable element of the relationship between counselling and IAPT, counselling continues to be represented in IAPT. After 12 years, counselling is the second most popular and relied upon approach to psychological therapy delivered by IAPT at its high intensity level; 50% less than, and second only to Cognitive Behavioural Therapy (CBT) (Clark, 2018). Counselling is important to IAPT, whether IAPT policy makers like it or not.

The relationship between IAPT and counselling has always been problematic. Games have been and continue to be played. In the words of Berne (1964, p.44), "A game is … a recurring set of transactions, often repetitious, superficially plausible, with a concealed motivation … every game … is basically dishonest …" Arguably, if from the outset, IAPT had presented its clinical and business intentions transparently, clearly rejecting counselling as a psychological therapy, acknowledging reliance on counsellors during the recruitment and training of its own practitioners, there would have been confrontation. However, there was an avoidance of the issues, leading to unresolved conflict. Games require players, and counsellors have arguably played their own roles, conforming, manipulating, and rebelling in response to the IAPT programme. Counsellors remained in IAPT, necessarily maintaining

PCMH services throughout IAPT implementation. With the benefit of hindsight, options for change were available. A simple and unambiguous statement of intent, with a clear role for counselling during the change period, followed by a programme of professional development for counsellors, would have been transparent and, to a degree, empowering for counsellors. In practice, no choice was offered, and games were played to maintain provision whilst implementing the IAPT treatment programme.

Putting the internal and external politics to one side, counsellors had choices – stay or leave. I was a counsellor in PCMH, on an unpaid voluntary contract when IAPT was implemented. I chose to stay in PCMH service and engage in the IAPT programme. I saw IAPT as an opportunity to professionally develop. I was studying for a Master's Degree in Counselling. I had aspiration to secure further training, qualifications, and perhaps permanent employment. Staying in IAPT, required conforming to the new approach, adapting to the treatment model and securing training as a CBT practitioner. I was offered (and accepted) a fixed-term paid contract to deliver counselling. This arrangement was repeated every three months, for two years, during which time recruits to IAPT were trained in IAPT approaches – predominantly CBT. I was unable to secure training in IAPT modalities during this time. I did not understand why I had been rejected, I was told that it was related to my employment status and suitability for making a transition to CBT. My naivety and ignorance contributed to the maintenance of this situation. Having, for personal reasons, secured permanent employment at an IAPT service in London (some 240 miles away from home), I was afforded and accepted training in Interpersonal Psychotherapy (IPT). This changed my relationship with IAPT. Two years later, finding myself an attractive IAPT employment prospect, I returned home, securing promotions and later becoming an IAPT service manager. Throughout my IAPT journey, and the different perspectives it offered me, I was motivated to help other counsellors understand how IAPT could contribute to their professional development. I had observed, that counsellors were not always available to the IAPT ideological approach to

psychological therapies. It is arguable that this is the only implication for counsellor's professional development in IAPT. Bryman's 'incommensurable' relationship between the treatment paradigm and counselling (and by association counsellors) required investigation. That is what this thesis seeks to address, that is why this research has significance for counsellors who have worked in or may work in IAPT. Understanding how IAPT can contribute to a counsellor's professional development is professionally empowering. In order to understand, it is necessary to comprehend IAPT, its business and clinical aspects, and how counsellors respond to those issues. Once aware, counsellors can make informed decisions and choices about how IAPT can affect their professional development – in short whether to engage in the games or to effect and maintain a valued professional relationship.

It is also worth considering, that as a researcher, my IAPT professional background will have an impact on this study. I have worked in IAPT as a therapist, on unpaid voluntary, paid temporary, and permanent contracts. As a manager, I have experienced the program from a different perspective, often in conflict with counsellors. My professional background cannot be discounted in relation to the findings, they are - in critical realist fashion - formed by myself, influenced by both my professional background (In IAPT) as well as the participants interviews. This is recognisable through decisions made in relation to what I chose to extract from the data, and how I chose to present and interpret those observations. I recognise this as both a challenge and benefit to analytical objectivity. I cannot argue that I have achieved pure objectivity, but the processes of internal and external evaluations, such as peer discussion, supervision, presentation of thoughts and findings, notes and diaries along the way have contributed to the outcome.

1.3 The Terminology of Counselling and Counsellor

In this study, there are some important clarifications to be had. The first of which is that we are dealing with counsellors. This question is worth presenting to the reader: do you know what counselling, or a counsellor is, and can you succinctly define that knowledge? Such a definition needs to distinguish between a counsellor and a psychotherapist. This question is addressed in the literature review. However, the definition adopted for this research is,

> Counselling is a non-manualised, idiographic approach to psychological therapy in which the individual worldview of the client takes primacy over the generalised, nomothetic knowledge and stance of NICE and a counsellor is a practitioner of that approach

1.4 Some Background of the Researcher

I worked in IAPT for seven of my eight years of NHS service, during the early years I just got on with what I had to do and was grateful for paid employment. I moaned and got frustrated with the system, just like everyone else (there was never any shortage of facilitators and witnesses). Prior to serving in the NHS, I had served for over three decades in law enforcement. Throughout that career, my professional development was specific to policing, and the varied aspects and specialities of policing. Midway through police service, I trained as a person-centred counsellor, experiencing PCMH provision on placement at a general medical practice in North West England during the mid-1990's. At this stage of my development as a counsellor, I presumed that I had acquired all the qualification needed for a career in counselling and that all I needed was experience. Upon retiring from police service, I undertook an honorary PCMH contract, facilitating my journey through PCMH, and subsequently IAPT. In the NHS I found a familiar culture, service ethic, and structure to which I could easily relate and adapt. Having decades of experience of working in a national

institution (policing), with all the support of appropriate professional development and support, I expected and presumed the same would be available to me in the NHS. I was disappointed.

Initially, I was employed on an honorary volunteer contract in Liverpool, providing counselling in response to a broad range of common mental health problems. After twelve months, I took a paid short-term contract of three months duration. This coincided with the implementation of IAPT in 2008. My journey in PCMH continued for a further two years, on a series of three-month fixed-term contracts. During this time the service became an IAPT service. Two years later, the service fulfilled its quota of IAPT trained CBT practitioners. Counsellors became redundant to service need and their fixed-term contracts were not renewed. Fortuitously, I had secured a permanent contract of employment at a London based IAPT service, with provision for a counsellor in its business plan. This service encouraged and supported me to train in the IAPT compliant model of Interpersonal Psychotherapy (IPT), enhancing services provision of IAPT compliant modalities and secured my employability in the IAPT programme. It was an example of how local management can use the IAPT programme to enhance its service capability, whilst supporting the professional development of its practitioners. After two years in London, I returned to Merseyside where I secured permanent employment as an IPT therapist and latterly as the service manager of that IAPT service. IAPT service management was a very different, personally unsustainable, challenge. It led to my decision to leave the NHS and undertake this doctorate.

The introduction of the IAPT programme to PCMH, with its transformation from service to business ethics, the change in managerial behaviours, and leadership values had stimulated resistance in myself towards IAPT. This was maintained by the belief that counselling was

undervalued, and counsellors were being deprived of professional development opportunity. During my IAPT service, I wrote a quarterly column in *Healthcare,* a British Association for Counselling and Psychotherapy (BACP) divisional journal (between 2013-2015), reflecting on my experiences and observations of working as a counsellor in IAPT (Appendix 1). My commitment to this subject, extended to participation in research conducted into burnout in IAPT therapists (Steel, MacDonald, Schroder & Mellor-Clark, 2015), and the challenges of working as a counsellor in IAPT (Proctor, Brown, Cohen & McKelvie, 2019). Also, undertaking an analytical autoethnographic study of my time spent in IAPT, addressing the effect it had on my professional development (Mason & Reeves, 2018). My interest is apparent in these publications, along with my contribution to research, and literature related to the subject of this Thesis. Doctoral study has benefitted my professional development. At the 2017 BACP National Research Conference, I presented my Analytic Autoethnography: *An Exploration of how Working in the English Improving Access to Psychological Therapies (IAPT) Programme, Might Affect the Personal and Professional Development of Counsellors;* subsequently published in the British Journal of Guidance and Counselling (Mason & Reeves, 2018). I also undertook a Thematic Analysis of *Understanding the Counselling Experience of Students Struggling with Mental Health Problems at University of Chester: The Student Perspective.* Presenting my findings at the Cathedrals Group and Colleges & Universities of the Anglican Communion, National Symposium on Improving Student Mental Health in 2019. I have joint authorship of a book chapter, outlining other key approaches to counselling and psychotherapy, including a description of IAPT therapeutic approaches (Reeves & Mason, 2018). I acknowledge and appreciate that my service in PCMH and IAPT has enhanced my knowledge, skills, and employability. Enhancing and facilitating my ability to monetise skills and experience by securing work as a Counsellor at two universities. Examining IAPT, through the perspective of others was the task I set for myself.

1.5 The Origin of this Research

This thesis originated from my experiences of working in the NHS as a PCMH counsellor. During a seven-year period of time, I worked as counsellor, psychological therapist, and manager in IAPT services. I observed counselling colleagues, and experienced for myself, personal and profession dissonance. Dissonance was commonly acknowledged, yet there was no explicit understanding of the ideological, clinical, and organisational values that informed and maintained this phenomenon. This phenomenon appeared to negatively impact upon the professional development of those counsellors. As a practitioner, I was able to tolerate, navigate through and subsequently thrive in IAPT. As a manager, I found myself conflicted. Unable to resolve or tolerate the distress of colleagues, obliged to work in a treatment paradigm running counter to my professional values and beliefs, designed to employ and professionally develop practitioners adhering to a nomothetic treatment paradigm. Furthermore, my managerial autonomy was severely constrained by NHS Trust Management, interpreting and committing to the orthodoxy of the IAPT programme. In particular, decision making in relation to the professional development of its employees and the convenience of CBT conformity.

The lack of research about implications for counsellor professional development in IAPT is an area that needs illumination. Informing counsellors, from a personal perspective and IAPT decision makers from an organisational perspective of those implications may benefit both parties. Hopefully, the broader and deeper knowledge emerging from this study will inspire further interest and encourage counselling colleagues to consider the challenges and benefits to professional development available in IAPT. Hopefully, it will serve to convince IAPT decision makers of the benefits of appropriate professional development for its counsellors.

1.6 A Commentary on the Current Situation

At the outset of this Thesis, I argue that what is being observed and reviewed is psychological therapy, the practitioners of which are psychological therapists, including counsellors. Psychological therapy is what IAPT provides. Counsellors, as proponents of psychological therapy, practice their version of therapy throughout the world. In England, counsellors are ubiquitous in the psychological therapy marketplace, in which IAPT occupies a distinct place, however IAPT was not designed for counsellors. IAPT was designed for the general population of English NHS service users to improve access to psychological therapies, termed evidence-based, across a continuum of mild to severe anxiety and depression. In order to understand why there might be implications for the professional development of counsellors (as psychological therapists) in IAPT, it is necessary to distinguish counselling from the psychological therapy that IAPT is designed to deliver – the two are distinct approaches to psychological therapy. Having done so, it is hoped that the reader may understand what a psychological therapist is in IAPT, and how a psychological therapist develops in IAPT, because that is what IAPT offers – professional development for its psychological therapists.

1.7 Research Question and Aims

The research question is: *What are the professional development implications for Counsellors who have worked in the English Improving Access to Psychological Therapies (IAPT) programme?*

The principal aims of this research are:

- To explore the degree to which counsellors engage with opportunities for professional development in IAPT service.

- To explore how facilitative [if at all] IAPT service is to the professional development of counsellors.
- To examine how counsellors, conceptualise and respond to the professional development opportunities available from IAPT.

1.8 Originality

Whilst research has been undertaken to establish the effect that working in IAPT can have it's on practitioners (Steele, Macdonald, Schroder, & Mellor-Clark, 2015) and in particular counsellors (Altson, Loewenthal, Gaitanidis & Thomas, 2015; Proctor, Brown, Cohen & McKelvie, 2019) the effect on counsellors professional development has not been researched. Therefore, this research makes an original contribution to knowledge. Previous studies have highlighted negative implications of IAPT service, this study has contributed by recognising, both negative and positive implications for professional development, placing that knowledge in the context of post-IAPT employability and professional growth. Originality is also evidenced in the definition of counselling for the purposes of this study. It is argued that a limitation in counselling research is the lack of definition of the term counselling. It is assumed that the reader knows what counselling is as distinct from other psychotherapeutic approaches. It is further argued that there is no definition of counselling relative to IAPT, that defines its process and practitioners. This has an effect on the provision of professional development for counsellors, and as a corollary the development of counselling in IAPT. These comply with the concepts of originality acceptable for doctoral research (Phillips & Pugh, 2015, pp.74-75).

1.9 Structure of the Thesis

This introduction has set out the context and reason for the research, explained the importance of clarifying terminology regarding counselling and counsellors. The researcher has been introduced, along with an explanation of the origin of the research. A comment has been made on the current situation regarding counselling and psychotherapy, distinguishing counselling from IAPT psychological therapy. The research question and aims have been set out, along with a broad claim of original contribution to be identified and discussed later.

Chapter One, will review the relevant literature applicable to the subject. Chapter Two, will outline the research methods employed, explaining the methodological, ontological and epistemological basis upon which the research has been undertaken. Chapters Three, Four and Five will present the findings of the research, reflecting the three identified themes. Chapter Six, offers a critical discussion of the findings, synthesising the data with literature, reflecting implications for counsellors professional development in IAPT. Chapter Seven, concludes the Thesis.

Chapter 2: Literature Review

2.1 Introduction to the Literature Review

Given the broad scope and context of the thesis, this review has been presented in the fashion of a discussion. Exploring and defining the terminology of counselling and counsellor employing a limited selective, pragmatic, narrative review of literature. A review of literature related to counsellor professional development, and a review of the literature related to IAPT. Particularly, its implementation related to counsellors professional development. Literature relating to IAPT is dominated by official IAPT publications and IAPT associated papers that serve to validate the programme, rather than critically appraise its results against the results of other UK PCMH services. IAPT is unique in that it has created a vacuum, then filled it with one option – IAPT. Beyond inter-service comparison (a league table) there is little to compare with IAPT. The IAPT proposition in 2008, was to replace rather than evolve PCMH provision for England. This IAPT literature would be repetitious in terms of traditional review. Other literature takes the stance of opinion-based opposition to IAPT, on account of IAPT being a treatment paradigm with no comparator, only inter-IAPT outcome data. However, this review seeks to make sense of the literature in a critical fashion. This review has not been easy to structure on account of the incommensurable relationship between counselling and IAPT.

A variety of databases were used to locate literature using the University of Chester, Learning and Information Services online provision (e.g. Ovid, PubMed, Ebscohost etc.) using keywords such as: counsellor, counselling, IAPT, Professional Development etc. As I researched and identified relevant and interesting literature, my search expanded through reading, referencing links, discussion with peers, and the use of internet searches on

platforms such as Google Search. This strategy enabled me to access knowledge across a broad, unrestricted scope.

2.2 Defining the Terminology of Counselling and Counsellor

In order to judge the aims of the research against the literature it is important to establish what defines a counsellor. At this point counselling and counsellor, along with professional development needs, can be placed in the context of IAPT. To achieve this, a selective, pragmatic, narrative review of papers published in the BACP research journal, Counselling and Psychotherapy Research (CPR) was undertaken. Papers with published titles including counsellor and counselling were reviewed over a ten-year period, between 2007 and 2017, to establish a working definition of the term counsellor. Evolving from this selective, pragmatic, narrative review the overarching literature review will consider the literature on the professional development of counsellors. Finally, the subject of IAPT, understanding how IAPT is designed and contributes to PCMH in England. Over the past 12 years, counselling has been ever-present in IAPT, representing the second most prominent approach to high intensity therapies (Clark, 2018). Throughout the existence of IAPT, conflict has been evidenced between counsellors and the programme. IAPT's response appears to have been confined to one document, setting out its relationship with counselling (IAPT, 2009). Since that paper, IAPT literature has focussed on its proclaimed success, declining to respond further to the challenges and criticisms of its critics. In contextualising the relationship between counsellors professional development and IAPT, it is helpful to consider the presence, purpose and contribution that IAPT makes to PCMH provision.

2.2.1 The Problem of Defining Counselling – A General Review of Historical Literature

Considering the above discussion and relating this back to the purpose of this thesis, the implications for the professional development of counsellors working in IAPT are complex. The lack of a clear professional identity for counsellors, is arguably a key aspect of that issue – what development could IAPT provide for a profession that is varied in its approach? Six decades ago, an early reference to counsellors in PCMH appears in the British Medical Journal. In a book review, Bennett (1960, p.1791) illuminates the lack of knowledge amongst doctors in the medical profession, relative to counselling and psychotherapy, by posing the rhetorical question "What do you actually do – is it just a matter of talking and giving advice?". The continuing general lack of understanding between the medical world and counselling was highlighted decades later. In its evidence based clinical practice guidelines relating to psychological therapies 'and' counselling, the Department of Health (DoH, 2001), imply difference between psychological therapy and counselling. Arguably, the title 'Treatment Choice in Psychological Therapies and Counselling' subtly, perhaps subliminally, excludes counselling from the discipline of psychological therapy. It seems to be a distinction that the professional associations representing counselling left unchallenged, even though the BACP contributed to the document. The document (DoH, 2001, pp.7-9) asserted that the distinction between the two (counselling and psychotherapy) was blurred, suggesting that counselling was concerned with the promotion of mental health wellbeing, whilst psychological therapy was concerned with treating disorders. It appears that a common practice in PCMH was to describe all psychotherapeutic practice as counselling, even though many counsellors were, "qualified psychological therapists" (p.8). To exemplify the lack of distinction between counselling and psychological therapy, the document describes counselling as such, "the patient's concerns are rephrased and clarified in order that he or she may develop a greater sense of wellbeing and cope with life difficulties differently" (p.9) and CBT as a psychotherapy, "Cognitive techniques (such as challenging negative

automatic thoughts) and behavioural techniques (such as activity scheduling and behavioural experiments) are used with the main aim of relieving symptoms by changing maladaptive thoughts and beliefs" (p.8). Arguably, the question posed by Bennett in 1960 ("is it just a matter of talking and giving advice?") may not have been answered in this document.

If counselling and psychotherapy are distinct along a continuum of psychological therapies, then Cooper and McLeod (2007) describe another category within the field: pluralistic; being a practitioner who treats psychological distress from a multiplicity of approaches and philosophical stances, without having to reduce them to one unified modality. Stiles, Barkham, Mellor-Clark and Connell (2008) differentiate CBT, Person Centred Therapy and Psychodynamic Therapy as being distinct by usual interventions and assumptions in relation to the character and causes of psychopathology. Corey (2009) on the subject of the theory and practice of counselling and psychotherapy, identifies himself as an integrative counsellor, using several terms interchangeably, and whilst his book title (Theory and Practice of Counselling and Psychotherapy) differentiates between counselling and psychotherapy, he doesn't. Corey recommends that counsellors should not be restricted to a single theory of psychotherapeutic approach. Explaining the process of psychological therapy, he utilises the terms counselling, psychotherapy, counsellor, therapist and practitioner in one paragraph alone (p.6). Moloney (2013) argues that counselling is distinguished from psychotherapy by the level of academic qualification, the length of client engagement, and even by counselling being considered a second career. Shean (2016), that there are fundamental differences at the epistemological and theoretical level amongst people who provide psychological therapy, and that the term psychotherapist is an unhelpful conflation used as an umbrella term to encapsulate this diversity. Pilecki and McKay (2016) whilst not using the term counsellor, helpfully discuss the gap between evidence-based practitioners (who they argue employ nomothetic principles to treatment) and practitioners

who may be recognisable to members of BACP, as employing idiographic principles to treatment. The term idiographic is described as focussing on a client's personal lived experience, whilst seeking to help the client develop a more congruent and satisfying life – 'as if' recovery from mental illness is distinct from personal lived experience with such a therapeutic outcome. Nomothetic approaches to therapy would reflect the evidence based, nomothetic and manualised types of therapy championed by IAPT training programmes, which rely on a hierarchy of evidence, such as randomised control trials (RCT) to establish diagnostic treatment protocols (Shean, 2016; see also Martin & Thompson, 2003; Pilecki & McKay, 2016).

In addition to the confusion over titular terminology (Counsellor or Psychotherapist), there is a further field of terms used to describe philosophical allegiances, methods, and modalities. In this field practitioners describe themselves as humanistic, non-directive, analytical, transactional etc. or identify with approaches such as gestalt, person-centred, psychodynamic etc. which contributes to the plethora of counsellors and/or psychotherapists in the field. There appears to be no starting point or base-level for the profession of counselling, raising questions regarding the affect a lack of clarity may have on counsellor professional development in a distinctly structured programme such as IAPT. Perhaps, such obfuscation contributes to or reflects a divide within the NHS between employees who describe themselves as counsellors, psychotherapists or combine both terms. In the wider arena, the decision makers who commission treatment options and approaches to common emotional problems may also have issue with understanding what they are commissioning. Considering all of the above it is perhaps understandable that IAPT, early in the programme, published its paper outlining the relationship between counselling and IAPT (IAPT, 2009); seemingly to distinguish IAPT psychological therapy from counselling. This paper will be reviewed later in the chapter. However, the issue of what is counselling and what is a counsellor remains unaddressed in the literature, particularly with regards to IAPT and

thereby this study. Therefore, it was considered an important ontological and epistemological aspect of this research to determine what can be known of the practitioners who work in IAPT delivering psychological therapies that are incongruent to the model, and how can that be known without first knowing what defines such a practitioner. In short what and how was being observed.

2.2.2 Introducing the Selective, Pragmatic, Narrative Review

The definition of counselling is an area that can confuse. It would seem that, within the profession, defining counselling seems to be superfluous on account of counsellors knowing - a priori - what counselling is, what counsellors provide, and what distinguishes counsellors from other psychological therapists. Other mental health professionals, service users, general medical practitioners, and others may struggle to define counselling without that deductive knowledge. This ambiguity is not eased by the lack of consensus amongst counsellors and counselling associations of what defines counsellors from psychotherapists (Spinelli,1994, pp.11-13). BACP, The British Psychoanalytic Council, and The UK Council for Psychotherapy, have been working in collaboration on the Scope of Practice and Education (SCoPEd) project for a number of years, seeking to “clarify the professions for the public, trainers, employers, clients and patients and other stake holders in this field” (https://www.bacp.co.uk/about-us/advancing-the-profession/scoped/) demonstrating the complexity and professional resistance to achieving the aim of counsellor and psychological therapist identity. In professional terms, it is difficult to attract validation within organisations such as the English NHS – arguably the largest employer of psychological therapists in the UK and Europe – when for the benefit of a manualised, evidence-based treatment paradigm (such as IAPT), counselling cannot consistently define itself, its value, or argue its relevance to that paradigm (and thereby its professional development needs). Understanding paradigm and relating it to IAPT is essential to grasping the misalignment of counselling and its associated professional development implications within IAPT, and therefore this research.

2.2.3 IAPT as a Treatment Paradigm

Paradigm is defined by O'Reilly and Kiyimba (2015, p.3) as, "a basic set of beliefs or assumptions adopted by a scientific community which define the nature of the world and the place of individuals in it". When related to IAPT this might illuminate the programme's nomothetic beliefs and assumptions about anxiety and depression, the nature of the programme and the place of its practitioners within it. Bryman (2012, p.714) describes, "a cluster of beliefs and dictates that for scientists in a particular discipline influence what should be studied, how research should be done, and how results should be interpreted" arguably, in relation to IAPT: what should be treated; how and what data should be gathered; and how outcomes should be interpreted. Michell (2000) argues that paradigms should accept critical inquiry, consider other approaches, adapting and developing if appropriate – arguably a limitation of the IAPT programme. In this review IAPT has been found to demonstrate little openness to criticality, both in practice and in the literature. Perhaps, reflecting a paradigmatic defensiveness in its determination of what is evidence, and a fixation towards treatment approaches, reflective of a positivist treatment paradigm. This has a profound effect on counsellors' professional development within IAPT. Williams (2015) argues strongly against the dominance of the positivistic RCT based research that informs IAPT, claiming that current quantitative data centric CBT research is deductive in interpreting outcome. This pattern (Williams claims) obstructs Beckian commitment to identifying new theories and cultivating hypothetical positions that are inductive in nature, resulting in IAPT practitioners being preoccupied with data that reflect what CBT achieves, rather than how CBT achieves its outcomes. Challenges regarding the IAPT treatment paradigm (and the place of counselling within it) are prominent in the literature, though few are research based (many are opinion pieces) offering critical appraisal. One such research-based paper (Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006) set out a favourable argument for counselling when compared to CBT in PCMH settings. A further paper by Stiles, Barkham, Mellor-Clark and Connell (2008) developed the argument for counselling by

re-running the previous study. Using a four times larger sample, restricting the sample to PCMH, they found counselling approaches tended to provide equivalent outcomes to CBT. In response, Clark, Fairburn and Wessely (2008) delivered a robust rebuttal of the findings, arguing that limitations in the methodology undermined the results through lack of control and poor data completion rates in the sample. Considering this rebuttal, it is clear to see the benefits of adherence to a paradigm (dictating what should be studied, how research should be done, and how results should be interpreted) exemplifying the commitment to the IAPT data completion strategy – a powerful tool in winning arguments and convincing decision makers. What is lost in all three papers (and the IAPT literature generally) is the commutuality that psychological therapy is effective. If counselling, lacking a clear and definable identity, cannot consistently define itself, then employers (such as the English IAPT programme) cannot know what they are employing, and therefore service its professional development needs. In relation to this study it is arguable that a lack of definition has limitations regarding what is being researched, or at worst lacks scientific rigour. In any case, the requirement for the counselling profession to formalise and validate its approach, clearly situating itself within the discipline of psychological therapy, is arguably long overdue.

Inability to define what a counsellor is in terms of research is not a new concept to consider. Mellor-Clark and Simms (2001) highlighted the effect of homogenising the term counselling (and its associated counsellor) in that a number of influential papers had highlighted serious failings in the use of counsellors in NHS general practice. Included in which were: lack of qualifications and/or accreditation and inadequate use of, or lack of supervision (Sibbald, Addington-Hall, Brenneman, & Freeling, 1993; Sibbald, Addington-Hall, Brenneman, & Freeling 1996; Naji, Atherton-Naji, Beattie, & Donald, 1998); lack of experience of working in medical settings (Sibbald, Addington-Hall, Brenneman, & Freeling, 1996; Clark, Hook, & Stein, 1997; McLeod, 1998; Naji, 1998); and a lack of professional awareness around

competency to treat problems (Goldberg, & Huxley, 1980). Highlighting methodological limitations in these papers, Mellor-Clark and Huxley point out that (within these studies) the term counsellor had been homogenised, inclusive of the roles of Community Psychiatric Nurses, Practice Nurses, Clinical Psychologists, Social Workers, and Health Visitors. Key claims in the Depression Report (2006) may have been informed by these papers. It was therefore considered a necessity to define the term counsellor and/or counselling (as distinct from other psychological therapists working in IAPT) for the purposes of this study.

2.2.4 Situating the Selective, Pragmatic, Narrative Review

I have held various titles in IAPT, amongst which were 'IAPT Counsellor' and 'Specialist Psychological Therapist' both describe the same therapist delivering the same therapeutic approach. In order to differentiate the terms, and how that affects the delivery of psychological therapies in the context of IAPT (with its related professional development implications for counsellors) a general review of literature on the subject of defining counselling and counsellors was undertaken. This review was inconclusive, many papers had been published prior to IAPT, therefore being contextually challenged. I decided on devising a Selective, Pragmatic, Narrative review of all papers published in Counselling and Psychotherapy Research Journal (CPRJ) over a ten-year period between 2007-2017. The aim being to establish a workable definition or description of counsellor and/or counselling relative to this study, contemporary to the IAPT programme. CPRJ was chosen as the established academic research journal of BACP, considered to be representative of the counselling profession in England (the geographical location of IAPT and this study) and also attracting academics from a counselling background across the globe. CPRJ is a journal of international standing, publishing papers from counselling academics across the cultural spectrum and therefore not limited to English counselling. Ten years was considered to be a workable period in terms of data volume. Papers were included with the words counselling and/or counsellor in the title (Book reviews were discounted) to establish

whether there were any definitions of counselling and counsellor that would be facilitative of this thesis. 140 papers were identified with the word counselling or counsellor in the title, from which 33 narrative extracts were considered on the basis of whether they represented a definition or description of counselling. Some extracts were secondary citations taken from literature outside of the inclusion criteria. In itself this is a finding, recognising that authors had resorted to divers published definitions and descriptive, indicating a lack of consensus for the term. A definition was taken to be a short narrative meaning of the term counselling, as opposed to a description or explanation of what it does. However, through a process of reflection on each extract and constant comparison across the narratives, I concluded that differentiation between the two was more subjective than objective. This suggested that a reason for the lack of a universally acceptable definition, may be that the term counselling is intuitive, perhaps reflective of its idiographically located purpose. However, this key aspect of counselling ideology presented me with an element of difference that distinguished counselling from IAPT approved psychological therapy approaches – counselling is idiographically located, whilst IAPT applies a nomothetic approach.

2.2.5 Selective, Pragmatic, Narrative – Findings and Discussion

It is worth considering that of 140 identified papers published in CPRJ over a ten-year period, only 33 narrative extracts provided a descriptive considered as a definition or description of counselling. The term counselling is not of itself descriptive or definitive, suggesting a vulnerability in terms of identity – particularly when related to counsellor's professional development in IAPT. Examples of implicit references to a lack of identity include Lambert (2007) on client perspectives of counselling,

When she said, "We've got a counselling service" I automatically thought, is that the same as a psychiatrist? then I thought perhaps it is, ... it must be that sort of service ... counselling is a different word for that sort of service, I suppose

Strong and Neilson (2008) discovered a similar lack of clarity, attributing strong media influence on client's perceptions of counselling. One client was unable to describe a counsellor, "Cos, they could come in any shape" (p.73). Another that, "Anyone could be a counsellor" (p.73). Lynass, Pykhtina, and Cooper (2012), and Prior (2012) reference young people's reluctance to engage in counselling; attributed to uncertainty regarding what is involved. Barr, Hodge, Leeven, Bowen, and Knox (2012) present the lack of clarity between emotional support, and counselling. Not knowing what counselling is or does was referenced by Thurston (2010, p.8), "participants wanted to have a clear idea or definition of what counselling might involve and what it could offer". McLeod and Elliot (2011) in a Selective, Pragmatic, Narrative review of counselling case studies, found little evidence of what counsellors actually do. Barkham et al (2018, p.8), evaluating research on the treatment of depression through counselling, argue for greater precision in defining counselling as a profession and practice. Such a lack of identity in the profession will have issues when related to the professional development of its practitioners, raising questions around what it is that is being developed.

The term counselling was observed to describe more than define, arguably creating issues for counsellor professional development from an IAPT perspective – if not generally. Counselling is variously described as being, "… a method of help that explores emotional, cognitive, and practical issues" (Graham, Manor, & Wiseman, 2007, p.220); " … a form of change agentry to facilitate social and emotional growth processes" (Harris, 2009, p.179); " … an evidence-based treatment for a variety of psychological difficulties" (Cooper & Reeves,

2012, p.306). None of these examples describe the element of idiographic stance (a common theme) thereby, failing to differentiate counselling from the nomothetic generalised IAPT approach. Others, highlighted the idiographic nature of the activity,

> *Counselling … is: (a) voluntarily chosen by the client; (b) responsive to the individual needs of the client or group; and (c) primarily intended to bring about change in an area of psychological / behavioural functioning*
>
> McLeod (2010, p.239)

> *the principal focus of the counsellor is on relating to the client in an empathic and non-judgmental way, such that the client can come to understand and appreciate themselves and their own experiences more*
>
> Killips, Cooper, Freire, and McGinnis (2012, p.95)

Lack of distinction between idiographic and nomothetic is worthy of consideration, particularly when considering the nomothetic stance of IAPT. In the earlier examples – as in the literature generally – it is assumed that counsellors are idiographically situated, and yet those examples could and may describe the practice of IAPT trained practitioners (Remember that these examples are from an academic journal dedicated to research on counsellors or counselling). In the second examples, the narrative is idiographically situated and could not describe the stance of an IAPT trained practitioner who applies NICE guidelines to a diagnosis of mental illness i.e. depression or anxiety. I felt that such a distinction between the idiographic and nomothetic would be useful in the definition of counselling for this study.

Other narrative extracts introduced counselling in specific contexts, again appearing to be reliant on a-priori knowledge and understanding of counselling: McLeod (2013, p.34) on Transactional Analysis, “an integrative approach to psychotherapy that incorporates a relational perspective on working with cognitive and behavioural change and the promotion of understanding and insight”; Mellor-Clark, Twigg, Farrell and Kinder (2013, p.15) on work-based counselling, “the provision of brief psychological therapy for employees of an organisation which is paid for by the employer”; Cooper, Pybis, Hill, Jones and Cromarty (2013, p.89) on schools counselling, “a skilled way of helping young people with personal and developmental difficulties”; Munday (2013, p.52) on bereavement counselling, “a form of counselling that focuses specifically on a client’s bereavement together with their thoughts, feelings and experiences that occur following a substantial loss”; Cooper, Mcginnis, and Carrick (2014, p.201), again on schools counselling, “a common psychological intervention for young people, particularly in the UK”; Vossler and Moller (2015, p.11) on family counselling, “largely preventative, dealing with life issues before they become serious problems requiring specialist interventions”; Tilley, McLeod, and McLeod (2015, p.181) on pluralistic counselling, “collaboration between client and therapist around aligning the ideas and preferences of the client with the skills and knowledge of the therapist”.

Other narrative extracts situated counselling in specialised contexts: Boyd (2007, p.93) explains that when working with the deaf client, “the work of counselling is to try to understand the world from the client’s perspective”; Thomas and Smith (2007, p.166) on counselling for chronic fatigue syndrome, “Counsellors not only assisted clients understanding of techniques for good management of the illness (including balancing activity and rest [pacing]) but also explored avenues of treatment and care. Emotional aspects of the illness were also explored during these sessions”; Gubi (2009, p.118) on the use of prayer in counselling, “the process of helping the client to unravel their personal constructs, in the

knowledge and trust that growth would come from that process". Finally, Goldman et al (2016, p.294) on the IAPT approved Experiential Counselling for Depression (ECfD),

> *… attentively listen … in a safe environment … to talk about their [the clients] situation and how they feel about it … a learning process where they can find out the reasons for why they are the way they are, learn new skills to manage their difficulties, which helps them to feel stronger and to gain some control over their lives*

It is argued that none of the above, drawn from a decade of published manuscripts, provides clarity in relation to counselling, or is sufficient for the purposes of defining a counsellor or counselling for this thesis.

2.2.6 Concluding the Selective, Pragmatic, Narrative Review

Throughout this review I grappled with the task of differentiating between definition and description. The above descriptions all represent counselling as flexible across a range of specialised, non-medicalised applications with the belief that counselling will result in psychologically efficacious outcomes (a belief that the IAPT literature will consistently challenge). Within the mental health professions, the term counsellor can be used to describe practitioners from different modalities i.e. psychodynamic counsellor, or person-centred counsellor. The diverse traditions from which psychological therapists draw their approach can make terminology, or shared language, an issue. In that regard, and for the purposes of this review, a counsellor will be assumed to be a psychological therapist who approaches treatment from an idiographic perspective i.e. focussing on the individuals lived experience of encounters, relationships etc. with a view to developing a more satisfying and integrated life. Non-idiographic manualised therapies and therapists, such as the IAPT

compliant modalities of a positivist approach i.e. Cognitive Behavioural, Interpersonal Psychotherapy will be referred to as nomothetic (Shean, 2016; see also Martin & Thompson, 2003; Pilecki & McKay, 2016).

2.2.7 The Proposed Definition

A key defining aspect of counselling is the priority of an idiographic stance over a nomothetic stance. Therefore, I decided the following definition would facilitate the research question by distinguishing counselling and psychological therapy approaches present in IAPT, and counsellor and IAPT psychological therapist would describe practitioners who adhere to those approaches,

> *Counselling is a non-manualised, idiographic approach to psychological therapy in which the individual worldview of the client takes primacy over the generalised, nomothetic knowledge and stance of NICE, and a counsellor is a psychological therapist who reflects that approach*

IAPT would not support such an approach. However, its own therapeutic approach can be described and differentiated using the below description,

> *IAPT takes a manualised, nomothetic approach to psychological therapy in which the generalised, nomothetic knowledge and stance of NICE takes primacy over the individual, idiographic worldview of the client. An IAPT compliant psychological therapist reflects that approach*

It is argued that this exercise defines counselling as an approach to psychological therapy, whilst also describing the IAPT therapeutic and clinical stance, providing a macroscopic or overarching definition from which divers approaches can further define and differentiate themselves.

2.3 Reviewing Counsellor's Professional Development

2.3.1 Professional Development, Counsellors and IAPT

Having established a working definition for the study, it is now worth considering the second aspect of the research question. The professional development of counsellors who fit that definition and have worked in IAPT. IAPT as an organisation is an imprecise description; IAPT is arguably a treatment paradigm, though it is branded as a programme set within English NHS PCMH (Clarke, 2011; Moloney, 2013; Williams, 2015). IAPT remains the unchallenged means of delivering psychological therapies at primary care level in England. Pope (2013) attributes its implementation to the rapid growth of the medicalisation of depression in the UK. The key operating principles of the programme are a universal (top down) measurement of activity and outcome, strictly controlled and monitored at a national level (Clark, 2013), such stringent environmental demands are not always suited to idiographic counsellors. An unacknowledged theme – latent within the literature – is the lack of professional development provision for counsellors. The professional development that IAPT provides is directed at nomothetic approaches developed by IAPT, for IAPT. In 2012, IAPT outlined several accreditation requirements for therapeutic modalities which it was supporting (IAPT, 2012), Low Intensity and High Intensity CBT, Brief Dynamic Psychotherapy – developed as Dynamic Interpersonal Therapy for Depression (DIT), Experiential Counselling for Depression (ECfD), Interpersonal Psychotherapy (IPT), and Behavioural Couple Therapy – developed as Couple Therapy for Depression (CTfD). On

successful completion of training, accreditation from aligned professional bodies is required. However, accreditation takes the form of accreditation in that modality, rather than the general accredited status which counsellors achieve through associations, such as BACP. In that regard, if counsellors engage with IAPT training it should be with the understanding that IAPT training is geared to the conversion of idiographic approaches into the use of manualised nomothetic approaches, such as CBT, ECfD, DIT, IPT and CTfD. It is worth considering the anomaly that ECfD has been accepted as a first line treatment by NICE (and adopted by IAPT) for depression, whilst also being championed by counsellors as being an idiographic approach to therapy (Proctor & Hayes, 2017; Goldman et al., 2016, p.294). Despite this ideological anomaly (an idiographic psychological therapy accepted within a nomothetic manualised treatment paradigm) Layard and Clark (2015) credit all IAPT training as being evidence-based and having made the mental health situation in England much better. Others may characterise such a claim as partisan, agreeing with Pilgrim (2011) who suggested a different perspective – one of rhetorical manipulation applied to the benefit of manualised therapies, particularly CBT. It is worthy of note that the people who control the treatment paradigm, and the professional development strategy that supports it, consistently champion what is referred to as evidence-based treatment (EBT). Counselling is not accepted as being EBT. A crucial point in the conflict is that what is acceptable to IAPT is only NICE approved EBT, irrespective of what works.

The subject of what works therapeutically is relevant to professional development. There is a group of studies that concern themselves with the question of whether idiographic or nomothetic approaches are more effective. Chambless and Ollendick (2001) published a review of empirically supported treatments (ESTs) undertaken worldwide, EST's being another descriptive for EBT. No approach was found to be superior in the treatment of adult depression, a finding in keeping with the studies discussed earlier by Stiles, Barkham, Twigg, Mellor-Clark & Cooper (2006), and Stiles et al. (2008). Irrespective, despite evidence

of equivalence in outcome across treatment approaches, CBT is afforded greater credibility across publications. This is true of the IAPT publications authored by Clark and Layard. Goeting (2009) highlights the change over from a PCMH service to IAPT, and the collection and use of data in performance monitoring by the Health and Social Care Information Centre (HSCIC) now known as NHS Digital. Early figures published by HSCIC demonstrated equivalence between idiographic and nomothetic approaches across IAPT services nationally (HSCIC, 2015). Equivalence paradox might be explained in ontological and epistemological terms, by recognising that individuals and organisational stances may differ on what is reality, and what passes as valid knowledge in the understanding of those stances (Bryman, 2012, p.711; O'Reilly & Kiyimba, pp.5-11). In the debate around effectiveness of approach, a key aspect is allegiance to ontology, epistemology, and ideology. This links to the subject of this thesis through professional development being a learning process; counsellors may dispute or dismiss learning that is ideologically opposed. The professional development offered by IAPT is nomothetically situated, directly opposed to a counsellors idiographic belief of what can be known, and how it can be known.

2.3.2 Relating Ontological and Epistemological Stance to Counsellor's Professional Development – Opinion-based Literature

The following literature is reflective of the opinion-based opposition to IAPT. Whilst expressing opinion and encouraging debate, it appears to have failed to generate responses from policy makers. Parker (2010) recognises ontological imbalance between the idiographic singularity of the client and the nomothetic objectivism of IAPT. Arguing that (from his perspective) the very dubious notions about human nature that underpin IAPT, plus Layard's strategy to offer people happiness (through a dose of CBT) may be well-meaning – but is mistaken. Ingham (2010) questions the governments right to decide upon what type of practitioner (and therefore ideological allegiance) is suitable for PCMH. Drawing on his experience of PCMH work, he questions whether the manualised short-term therapy being

provided by IAPT trained nomothetic practitioners (rather than the indeterminate approach of experienced idiographic practitioners) is efficacious; whilst the ideological challenge to counsellor's professional development is understandable, Ingham does not offer any guidance on how counsellors might respond to that challenge. House (2012) is critical of the centralised, manualised, therapeutic controls exemplified by IAPT's audit culture – highlighting the fundamental difference presented through the nature of conscious level proceduralism, and the psychodynamic sub-conscious experience. Expressing scepticism about IAPT's reliance on its manualised version of the psychodynamic approach (DIT). House describes the organisational belief that adherence to the manual will provide good outcomes as superficial positivism. House also considers the need for counsellors (in remaining true to their core-beliefs) to engage in 'principled non-compliance' towards IAPT. Rizq (2013a) engages the theme of political conspiracy, arguing that IAPT is tightly structured and held together by an Orwellian use of banner terms, such as 'evidence-based' 'competency frameworks' and 'NICE compliant therapies'. Rizq suggests that such use of language reduces the need to consciously reflect upon or extrapolate meaning, defining its own authority, and confirming the bio-medical evidence-based regime that it represents. Rizq (2013b) later suggests that the IAPT obsession with organisational monitoring and measurement threatens counsellor development. Citing rituals of verification, such as data collections and outcome monitoring, that may desensitise staff against the emotional distress of the client. The tacit message within the literature (and in these examples) is one of the ontological, epistemological and ideological allegiance, informing resistance from counsellors toward IAPT and presumably any professional development on offer within its programme.

2.3.3 Relating Ontological and Epistemological Stance to Counsellor's Professional Development – Research-based Literature

Arthur (2001) found, in a review of 45 papers exploring therapist personality and epistemological allegiance, that there was a strong epistemological divergence between psychodynamic practitioners (idiographical stance) and cognitive behavioural therapists (nomothetic stance), and that this had implications for choice of orientation, professional satisfaction, and integrative availability. This might suggest that idiographic practitioners, for ideological and epistemological reasons, are less suited to change or flexibility in orientation from an epistemological perspective. However, there is literature demonstrating that IAPT offers professional development to counsellors within its paradigm, contingent (one imagines) on counsellors accepting, or being flexible to IAPT's ontological, epistemological and ideological stance. IAPT counsellors who 'converted' such as Lemma, Target & Fonagy (2010) highlight that the IAPT belief in positive outcomes (described by House as superficial positivism) is validated through the process of therapists being video or audio recorded, and then rated, during trials of the model – a point which House fails to recognise in his argument against the manualised approach. Gelman, McKay and Marks (2010) report on their experiences during the IAPT DIT pilot study. Initial concerns of how psychodynamic practice may not accord with the application of measures, were alleviated through sensitive application of the measures, enabling their use within the psychodynamic relational context; fears of therapist desensitisation through regulation were rejected. In confirming the validity and relevance of manualisation in IAPT, clear appreciation of the nomothetic approach and its effectiveness is evident amongst adaptive counsellors, counterbalancing the fears of IAPT's opinion-based opposition. IAPT appears to offer counsellors opportunity for professional development, if only to extend to nomothetic approaches or become ontologically and epistemologically flexible, and yet there remains resistance to this professional development approach amongst counsellors.

Proctor and Hayes (2017) observe the professional development challenges of counsellors training in ECfD. The impact of culture and value clashes, between counsellors and the IAPT programme is discussed, in the context of delivery of training for a manualised version of person-centred counselling. Issues such as integrating the IAPT minimum data set (diagnostic outcome measures) into a person-centred approach, the use of clustering (a diagnostic tool), trainees resistance to organisationally mandated training, limits on the amount of sessions available are discussed. The lack of provision for, and valuation of reflective practice, and the ethical conflict between the IAPT medicalised approach to therapy and the person-centred non-medicalised approach are also presented. Their observations are reflective of counselling not fitting into the IAPT model, and of the professional development (in the form of ECfD) offered to counsellors in IAPT being an ethically informed challenge for the individual counsellor to independently resolve. The discussion situates the task more in terms of counsellors surviving, rather than professionally developing in IAPT, finding an individual resolution to the ontological and epistemological challenges presented by IAPT, rather than offering solutions. Mason and Reeves (2018) explore the resistance to ideological and clinical change that IAPT presents from a professional development perspective. Recognising the value of embracing both idiographic and nomothetic approaches, the authors propose ideological flexibility and integration in a pluralistic approach to the IAPT treatment paradigm, thereby thriving rather than surviving, growth rather than stagnation.

The IAPT supportive literature is consistent and predictable, perhaps reflecting a strategy of non-engagement in such debate. Clarke (2011) acknowledges the influence of NICE to the success of the IAPT programme, recommending the EBT that IAPT has adopted, though he makes no reference to the effect on its practitioners from a professional development perspective. Furthermore, Layard and Clark (2014; 2015) authoritatively continue to promote EBT, leveraging their paradigmatically based outcome data – clinically and politically – to

support their contention that the IAPT programme is world beating, needs to double by 2020, and that the cost to the taxpayer would be recouped through savings made in benefit payments for mental ill health. This repetitive narrative – which began in 2005 – serves to reinforce the manualised nomothetic approach to psychological therapies, whilst undermining and by implication invalidating idiographic approaches. IAPT rhetoric, and the self-validating, prognostic impact of papers published by Clark, Layard, and their associates, place counsellors, committed to idiographic approaches, in a professional development dilemma that appears to offer them a choice between re-training in IAPT approved EBT's or PCMH obscurity.

2.3.4 IAPT Ontological and Epistemological Influences on Counsellor Professional Development

The implications for professional development amongst counsellors working in IAPT, cannot be considered without regard to the strong divergence between the main two types of psychological research and practice evident in the broader profession of psychological therapy. Quantitative in nature, is the dominant biomedical ideology that takes an ontologically realist, and epistemologically positivist stance to research and practice. This is the approach adopted and exemplified by IAPT. This stance demands adherence to the NICE approved standards of what is acceptable as EBT within that paradigm. Conversely (and qualitative in nature) is the non-biomedical ideology that takes an ontologically broader (encompassing diverse stances on what can be known) and epistemologically idiographic (because what can be known can only be known through the clients worldview) therapeutic approach that is often represented as counselling. The idiographic stance has no allegiance to (or support from) NICE guidance and from the IAPT perspective is organisationally invalid. Parrott (1999) highlights the great importance placed on the recognition of an individual worldview in counselling; a value not shared in IAPT nomothetic positivist ideology. Rizq (2011) argues that society's search for a cure for unhappiness, reflected in Layard's

publications (Layard, 2005a, 2005b, 2005c), is reliant on NICE approved evidence-based practices, placing counsellors in the role of an epistemological 'disorderly crowd' – perhaps indicative of House's 'principled non-compliance' (House, 2012). Lewis (2012) was conscious of dissatisfaction, related to professional development, amongst counsellors in IAPT suggesting that CBT therapists were favoured. Shean (2016) writes from a northern American perspective. Whilst IAPT does not exist in Northern America, there is a clear similarity between his criticism of EBT and the criticisms levelled by English counsellors towards the development and use of EBT in IAPT. Arguing that epistemologically, RCT's limit how studies are operated and evaluated, privileging EBT over idiographic approaches. These ideological differences (being polarised between idiographic and nomothetic) have implications for the professional development of counsellors seeking growth in an organisation aligned to a nomothetic ideology. Ideological alignment may present challenges to counsellors in IAPT, relative to the challenges of ideological change required to engage in professional development opportunities.

The subject of change is described by Norcross, Krebs and Prochaska (2011), considering stages of change (albeit in relation to addictive behaviour). Five stages are identified: *pre-contemplation*, in which people around the person are aware of issues but the individual has no awareness of the need for change; *contemplation*, were individuals become aware of an issue and are considering the need for, and the amount of effort required against the benefits of change; *preparation*, whereby individuals consider the required actions, perhaps taking preliminary steps or experimenting with change; *action*, when individuals undertake a planned series of actions around achieving change; finally *maintenance*, having undertaken change, the individual is content to maintain and consolidate new behaviours, assimilating change into everyday practice, thereby reducing the possibility of remission. Given the ideological context of professional development in this study, it is suggested that passing

stage one (pre-contemplation) into stage two (contemplation) would present counsellors with deeply challenging tasks regarding values and beliefs.

In a study by King (2007), counsellor's attitudes and expectations in relation to training courses were perceived as vocational, rather than employment focussed. This stance might limit counsellors' choices around IAPT approved opportunities, as IAPT offers employment focussed nomothetically based manualised training. There are clear indications, amongst the literature, of counselling being more vocational than occupational. Introducing the concept of counsellor professional development being more than the development of interventional skills related to method. Ronnestad & Skovholt (2003), discussed the drive for counsellors to have close alignment between professional and personal self, needing to engage in work that is compatible with the self, thereby fitting with theory on vocational development as being linked to implementation and integration of the self. Auxier, Hughes and Kline (2003), exploring the development of counsellors in training found that counsellor's a professional identity developed personal synthesis of values around: professional responsibilities; ethical guidelines and standards; professional memberships; personal experiences, and values. Du Preez and Roos (2008), explore the development and identity of counsellors, inextricably linking both, quoting one participants acknowledgement of the personal and professional self, "My work should be an extension of myself. I am a therapeutic instrument …" (p.705). Kern (2014) explored the integration of counsellors self, relative to the vulnerability this can create regarding their professional identity. Moss, Gibson, and Dollarhide (2014, p.3) studied postgraduate counsellors over a 5 to 25 years career span of experience concerning the development of professional identity; findings provided an interesting perspective on the suitability of IAPT prescriptive professional development for counsellors. They found,

- An increasing higher order integration between professional and personal selves

- Continuous reflection is required for optimal learning
- Intense commitment to learning drives development
- Professional development is continuous, lifelong, and can be erratic
- Clients are influential to counsellor development
- Personal life experiences are influential to counsellor development
- Interpersonal sources (i.e., mentors, supervisors, counsellors, peers, family) are influential to counsellor development
- Thinking and feeling about the profession and clients change over time.

Guy, Loewenthal, Thomas and Stephenson (2012) suggest a paradigm war between the proponents of counselling as a dialogical approach to emotional distress, and psychotherapy as a drug. Identifying and reducing both paradigms into their respective elements, a comparison is offered to validate each and to demonstrate the differences. In conclusion, a recommendations are made that: NICE opens itself up to the possibility of an epistemologically pluralistic approach to psychological therapies; that mental health is unsuited to the biomedical model of research and guidance; and that health has a broader meaning in relation to the psychological than it has in the physiological sense. Pilecki and McKay (2016) pragmatically discuss the gap between EBT and the idiographic approach, highlighting that physicians take a pluralistic approach in evidence-based medicine – relating to the medical evidence, whilst adapting interventions for the individual. A case for evidence based versus evidence dictated is offered and suggested for psychological therapy; an approach which could provide a rich source of professional development for all IAPT therapists, both nomothetic and idiographic. What is clear amongst the polarity of literature is that the humanistic or idiographically informed authors are more open to pluralism than the manualised or nomothetic authors. Perhaps this is indicative of the Norcross theory of change and them occupying a pre-stage, whereas the humanistic authors appear more open to change, suggesting pluralistic approaches.

2.4 Contextualising the IAPT Story

2.4.1 The PCMH Service Environment - Pre-IAPT

Prior to exploring the literature reflecting the implementation and operation of IAPT, it is worth observing the conditions that existed, and contributed to the creation of IAPT. This will help to set the context of PCMH, and the role of counselling and counsellors in the services that were replaced by IAPT implementation. Perhaps surprisingly, given the scope and expense of IAPT, there had been no national evaluation of PCMH services in the UK, or England in particular. Therefore, there is no base line of service provision to compare the emergent IAPT services with, other than those services in Scotland, Wales, and Northern Ireland whose devolved governments and NHS did not implement the IAPT programme. Counselling and counsellors are therefore measured on performance by their outcomes in a paradigm that was not designed to provide those services or develop those practitioners commensurate to the aims of that programme.

Corney (1990) called for a review and evaluation of counselling in PCMH, making four key assertions regarding what type of psychological therapies work in general practice: some clients may benefit more than others – therefore efforts should be made to establish and target clients who will benefit the most; some clients may be harmed by therapy – suggesting that intervention might disturb established client coping strategies; availability of a wide range of therapeutic approaches – should result in matching approach to client preference; when matching clients to therapy it is important to understand what level of training and skills are necessary to benefit clients. Corney clarifies counselling as comprising a broad range of therapist and intervention, including psychologists, social workers and nurses. There does not appear to be any clear outcomes across the range of counselling effectiveness studies that Corney reviewed. The term counselling is excessively inclusive of

clinical psychology, individual and group cognitive therapy, directive and non-directive, and 'Rogerian' counselling delivered by trained, volunteer, ancillary, and private practice counsellors, community nurses, clinical psychologists, social workers, and even general medical practitioners.

The closest pre-IAPT evaluation of PCMH service, is arguably the paper 'Treatment Choice in Psychological Therapies and Counselling: Evidence Based Clinical Practice Guidelines' (DOH, 2001) highlighting a lack of standardisation and guidelines for psychological treatments. This document presaged the NICE guidelines for common mental illness, claimed to be influential in the development and adoption of IAPT (Clark, 2011). In scope, the document sets out to provide guidance relating to the treatment of common presenting problems, such as anxiety, depression, post traumatic disorders, eating, obsessive and compulsive, personality and related psychosomatic disorders. With such scope its 16k word count is limited, particularly in comparison with current NICE provision of guidance – this document may have signposted a need for more detailed guidance. The reported lack of national standardisation across PCMH services, poor outcome measure compliance, and deficiency of research, appeared ineffectual in supporting counselling as a first line treatment for PCMH purposes. Any perception that psychological therapies and counselling employed were efficacious, and economically viable were limited through lack of generalised findings the nation (DOH, 2001). Mellor-Clark, Simms-Ellis and Burton (2001) undertook the first national survey focussing on PCMH counsellors working at general medical practices. Counsellors were employed at 466 of 907 practices contacted. The vast majority of counsellors were found to be adequately qualified, clinically supervised, and meeting criteria set out by national regulating bodies. However, while counselling was ubiquitous in GP practices, no data was considered on the efficacy of the counselling provided. Bower, Rowland and Hardy (2003) undertook a systematic review and meta-analysis of seven relevant clinical trials to compare the effectiveness of counselling, CBT, and anti-depressant

medication in PCMH. Across these trials, counselling was found to be moderately effective in the short-term reduction of psychological symptoms, but comparatively may not differ from the effects of CBT or medication. Gibbard and Hanley (2008) undertook a five-year evaluation of the effectiveness of person-centred counselling at one PCMH service, finding that counselling was effective with common mental health problems, including anxiety and depression across mild, moderate, and severe levels. Whilst concerns were highlighted, pre-IAPT, regarding the clinical and cost effectiveness of counselling, the data collection strategies at that time seemed lacking. Consequently, data related to clinical effectiveness and cost of counselling was unavailable to compare with approaches, such as CBT. Perhaps undermining the position of GP counselling and advancing the argument for IAPT.

The lack of reliable evidence and research to support counselling approaches set the scene for the delivery of a consistent model of national PCMH delivery. A subsequent review (starting in 2004) of psychological treatments facilitated the publication of the National Institute for Health and Care Excellence (NICE) guidelines for depression and anxiety (NICE 2004a, 2004b, 2005a, 2005b, 2006, 2009a, 2009b, 2011) mandating the use of diagnosis, adherence to treatment plans, consistency of practice, and reliance on research-based evidence derived from RCT and expert opinion. Norcross (2002) highlights limitations in the adoption and reliability of RCT's in psychotherapy, such as: the grouping of participants under single diagnostic banners being presumptive of homogenous groups (p.6); attrition during treatment (common in psychotherapy) affecting the random assignment aspect (p.316); and the possibility of researcher ideological allegiance creating analytical bias (p.316). Holmes, Murray, Perron and Rail (2006) argue against the hierarchy of evidence developed and maintained by the Cochrane Group, for which RCT is the only acceptable epistemological standard in the establishment of truth. Arguing, that the consequent exclusion (and diminishment) of qualitative research findings amongst many academic and scientific establishments has a marked effect on counselling, and the provision of

psychological therapies in IAPT. Grant (2009) questioned the scientific assumptions that lead to an overwhelming dominance of quantitative-experimental approaches that underpinned CBT. Amongst other issues, Grant emphasized the exclusion of counselling approaches from IAPT on this basis, highlighting the role and influence of narrative from a Foucauldian perspective in this process. Discussing the prominence of CBT in IAPT, Grant questions the assumption that clients present the coherent, single set of problems represented in the IAPT CBT training curricula; thereby diagnosable and remediable using EBT supported by RCT's. Grant exhorts CBT practitioners to be critical of the 'regimes of truth' that maintain social, professional, and political power that he claims to be ontologically and epistemologically questionable. These regimes of truth, serve to exclude the efficacy and value of counselling.

NICE guidelines subordinate counselling to clinical approaches that have been manualised by IAPT, such as CBT, DIT, & IPT. Mollon (2008) writing in 'The Psychologist' letters column, challenged the promotion of CBT as the only viable therapeutic option in PCMH, asserting that the official discourse in literature and professional journals was selling an argument for CBT, that was not scientifically factual or critical in nature. Mollon argued that the direction IAPT was taking was resulting in a lack of engagement with coexisting modalities in PCMH, such as counselling, to the detriment of patients. Suggesting a conflict of interest for David Clark, the prominent IAPT strategist, policy maker, and recognised CBT champion. Mollon highlighted the appointment of Clark as a government advisor for IAPT. The argument was met with a firm editorial rebuttal. In a later peer reviewed opinion piece, Mollon (2009) appraising NICE guidelines, argues that whilst NICE was originally designed to assess cost effectiveness and efficaciousness of medication in the NHS, the guidelines had become a medicalised, prescriptive, and prohibitive set of governing principles for psychotherapy. Highlighting the political and scientific credibility, and the coherence of clinical approach and training, which NICE guidelines and protocols bring to psychotherapy –

Mollon concludes that these very attractions deter the evolution of the art of psychotherapy. In a similar peer reviewed opinion piece, Ingham (2010) questions the government's right to regulate psychotherapy, fearing that presenting a solution to psychological distress was politically motivated. Highlighting the recruitment of trainee therapists for the government supported IAPT programme, Ingham posits that manualised training encourages therapists to recognise symptoms over underlying illness, excluding counselling's ideological value of learning from the patient. Calling for recognition of the knowledge and experience of established Jungian psychoanalytic practitioners, Ingham posits that short-term therapy (an IAPT objective) is efficacious but best delivered by therapists whose training is long.

The training referred to by Ingham, and the opinions offered by other academics and practitioners need contextualising to this study. Training is professional development, the impact IAPT had on counselling as a treatment approach in PCMH was significant. The resultant undermining of counselling and its lack of presence in PCMH had a commensurate impact on the availability of professional development to those counsellors who remained in IAPT. This section has sought to provide an understanding of how PCMH looked pre-IAPT, with its relationship to counsellors professional development. The following section will explore the literature from implementation of IAPT to the current period.

2.4.2 The Implementation of IAPT

The final piece of the jigsaw was the implementation of the IAPT programme. Since implementation (DOH, 2008) the provision of counselling and other psychological therapy in England has been reduced to a few manualised therapies supported by the NICE guidelines for depression and anxiety. Counselling was restricted to a recommendation for mild to moderate depression only – and only – after a patient declined CBT, IPT, Behavioural Activation, or Behavioural Couples Therapy (Clark, 2011). To reach this position there had

been a campaign for a change of direction regarding PCMH approaches. In 2005 Richard Layard, a Labour peer and professor of economics, formulated a proposition, leveraged on the concept of a national mental health crisis – with a proposed mechanism for successful remedial action (Layard, 2005a; 2005b; 2005c). This was the genesis of IAPT. In January 2005, Richard Layard and David Clark addressed the government, No.10 Strategy Unit seminar on Mental Health (Layard, 2005a) proposing that mental illness was, "one of the biggest causes of misery in our society" (p.2). Layard, an esteemed economist, and Labour peer drew a direct correlation between loss of value to our economy and income to our exchequer with mental health. Arguing, that the next phase of NHS reform – being chronic disease – should include greater emphasis on mental illness. Layard claimed modern psychological therapies performed as well as drugs, and that CBT should be adopted as the primary method in NHS PCMH. In order to achieve this, 10k CBT therapists would need to be trained over five years; an extra 5k clinical psychologists recruited (doubling the number in training); greater recruitment of psychiatrists; and a number of other actions which included NHS provision of self-help materials, and the inclusion of a pathways to work programme. Leveraging mental illness as an economic impediment, Layard and Clark argued that the adoption of EBT (effectively CBT) and major investment in NHS mental health resources, coupled with pathway to work programmes would improve the alleged national crisis. Having received government support Layard extended the arguments to a wider population, presenting his plans at the inaugural lecture of the Sainsbury Centre for Mental Health (Layard 2005b). Later, repeating the proposals to an academic readership through a publication focussed on economic interests (Layard, 2005c). Repeating the economic imperatives and assertion of a national mental health crisis, the need for more therapists, the efficacy of CBT, and the notion of EBT being the solution. Layard was clear about the type of workforce that was to be recruited; explicitly (and ironically for a labour party Lord) encouraging career change and professional development for non-therapists outside of PCMH, whilst implicitly excluding incumbent workers from such opportunity (little knowing that many would lose their jobs) – counsellors were not included in his narrative,

> *… two-year training would be offered to people with suitable experience and credentials – mental health nurses, social workers or occupational therapists – provided that, once trained, they were expected to change their job to become full-time therapists*
>
> (Layard, 2005c, p.20)

The diminishment of counselling as a first line psychological therapy had begun, privileging non-therapists over the incumbent counselling workforce,

> *There is no point at all in expanding provision via second-rate therapy and it would not be justified on economic grounds – just as there is a major question mark over much of the counselling that GP practices currently provide for lack of any other way to provide talking help to their patients*
>
> (Layard, 2005c, p.20)

Layard advanced the goals of teams of therapists, properly managed and supervised, enjoying mutual support and clear prospects for professional advancement, that could treat patients near to their home. To the naive reader, this may suggest that PCMH teams enjoyed none of these qualities or circumstances or were untrustworthy. Layard argued that current GP led mental health services should be made independent, and that patients could self-refer if they didn't wish their GP to know of their problems. These centres would be headed by psychologists and concentrate on CBT, wait times would reduce, and such resources would be available within 5 years. Layard claimed that the details of his vision drew heavily on his recent book, 'Happiness: Lessons from a New Science' (Layard, 2005d), in which he proposed many compelling facts and arguments on the subject of economics

and happiness, of which the underlying philosophical stance appeared to be utilitarianism. The developing IAPT programme, at this point to be uncovered, would certainly seek to accord with the qualities and values of utilitarianism.

2.4.3 The Depression Report

The culmination of Layard's activities on the proposal for PCMH change came with, arguably, his most influential publication. In 2006 nine people signed a document known as 'The Depression Report' (LSE, 2006), amongst them Professor Lord Richard Layard and Professor David Clark, published by the London School of Economics and Political Science (LSE) Centre for Economic Performance - Mental Health Policy Group. It repeated the arguments made out previously by Layard, presenting bold statements, such as "Crippling depression and chronic anxiety are the biggest causes of misery in Britain today" (p.1); "At the surgery one third of those who appear each year have mental health problems, and they take up at least a third of GP time" (p.3); "We are talking about people whose lives are crippled by their distress" (p.3). Such bold statements (lest they added to the claimed misery) were accompanied by a solution. The argument for which, was supported by statistical data presented in simple graphics. The solution was the delivery of cost-effective therapies (CBT and medication) with reports of short-term to long-term success rates of about 50%. The economic argument was supported by recovery from illness and the ability to return to wage earning, meaning that the proposed revolution would pay for itself over a seven-year period. The individual cost of treatment was calculated at £750, a figure that equalled an estimated monthly cost of invalidity benefit and lost taxes attributed to an individual suffering with depression and/or anxiety (see also Layard, Clark, Knapp, & Mayraz, 2007). It was proposed that the implementation of NICE guidelines for anxiety and depression, was achievable by recruiting and training ten thousand more PCMH therapists, working in teams, to a seven year centrally funded and commissioned plan. The Depression Report was disseminated widely – included in every copy of the Observer Newspaper on

Sunday 18th June 2006 – ensuring that the programme was highly visible, some might contend that this was the final action in a strategy of manufacturing consent.

Layard and Clark became the key proponents and contributors to the IAPT programme. The latter continuing to this date to hold the position of IAPT National Informatics and Clinical Advisor. Layard's obsession with happiness and curing mental illness through CBT was observed by Pilgrim (2008), critiquing Layard's book on happiness (Layard, 2005d), and whilst not addressing IAPT directly, Pilgrim highlights Layard's preference for the use of elaborate facts, using a style that relies on people's naive realism in the arguments for his preferred concepts. Whatever criticism might be directed at the qualities of Layard's publications, it cannot be denied that they achieved his purpose. It is claimed by Clark (2011, p.320) that overall political commitment for IAPT had already been secured in 2005, perhaps supporting the observation that Layard had undertook to secure general consent through his aforementioned papers and the depression report. IAPT had now reached its pilot stage, prior to implementation.

2.4.4 The IAPT Pilot Study

Clarke et al, (2009) report on the establishment of two IAPT pilot sites in 2006, at Doncaster and Newham. The paper outlines that IAPT had its roots in three key clinical and policy developments: a review of evidence for the effectiveness of interventions used – resulting in support for a limited number of psychological therapies; economists and clinical researchers arguing that increased access to psychological therapies would be self-funding, by reducing welfare benefit pay outs and medical costs – whilst increasing tax revenues through people returning to work; funding of two pilot projects to test and inform a national rollout of the CBT dominated, NICE guidance compliant, stepped-care model. Both sites focussed on patients suffering from anxiety and/or depression. The sites differed from the perspectives of

ethnicity, with the former being a predominantly white demographic, whilst Newham had an ethnically mixed population. Both low and high intensity interventions were offered. Outcome measurements were assessed as having a high data completion rate over the twelve months of the pilot, and despite challenges attributed to start-up problems, both sites reported significant achievements from a business and clinical perspective. An impressive number of people were treated at both sites (approx. 3500 people). Recovery rates were estimated at between 55-56%. Increase in employment without claiming sickness benefits was 4% at Doncaster and 10% at Newham. There was some inconsistency in NICE compliance across the sites, calling for more attention in planning and diagnosis. Overall, the IAPT pilot sites proved successful, paving the way for National IAPT implementation.

2.4.5 The National Implementation of IAPT

The IAPT implementation plan (DOH, 2008) provides a summary of key actions required for the forthcoming twelve months, including: an IAPT training plan that would include commitment to the national curricula for both low and high intensity practitioners; a commitment from each strategic health authority to commit two of its primary care trusts to providing an IAPT service; enough therapists to deliver the low and high intensity therapy to the population of that trust; at least a third of practitioners to be fully trained, managed and supervised, and to support the trainees with appropriate training; regional performance indicators to be agreed across strategic health authorities, related to the number of Primary Care Trust services implementing IAPT services; 3,600 therapists to be in training, and 900k people accessing treatment, with a 50% recovery rate, and 25k fewer people on sick pay and benefits. Timescales, governance and funding were also to be established. The document reflects the substantial financial investments in IAPT, and commitment to change. The plan included guidance on the characteristics of an IAPT service, how to move forward, funding, performance indicators, service standards, and monitoring. The chief executive of the NHS at that time gave the foreword, acknowledging IAPT as, " … new, state-of-the-art

psychological therapies services [that] will … demonstrate a paradigm shift in meeting the needs of a large group of people" (p.1). It was a breathtakingly ambitious undertaking.

Clark (2011) undertakes a broad post-implementation review of progress with IAPT, largely cheerleading the success of the programme to date, with little criticality in relation to other available approaches. Clark highlights personal concerns regarding non-IAPT services in relation to continuing lack of consistency in training, supervision, NICE guidance conformity, and data collection compliance. Following the perceived success of the programme, in 2011 the government committed an extra £400 million to complete and extend the IAPT programme. The IAPT programme was constantly under review, a quality that would encourage the objective observer, using the data collected to assess performance against the promises of a solution to the mental health crisis that was made out by Layard. This review process is reflected in publications made in the literature. Gyani et al, (2013) the authors of which include Clark and Layard, review the progress of the first year of IAPT. The review was broad, including a detailed examination of the data collected across the programme, measures used, the employment of the stepped care model, performance of both low and high intensity therapies, clinical performance, and human resource matters. Repeating and validating the arguments for the implementation of IAPT, focussing on the use of data, they conclude that data compliance, NICE compliance, and the IAPT model contributes to efficiency in service delivery and reliability in clinical outcome. The lack of critical appraisal regarding other treatment options outside of the IAPT model is striking. To the objective observer it might appear that no other option beyond manualised therapies existed. The paper concludes by asserting that whilst IAPT outcomes are not compliant with the rules of RCT, it is possible to see whether the results achieved in RCT can be replicated in routine PCMH at a national level. The implications for practice being the use of session by session outcome monitoring to ensure data completeness, and that the services who performed to the highest degree were compliant with NICE guidelines and IAPT modelling. It

is worth considering how this is achieved in practice, with its obvious effect on a workforce. Whilst IAPT has never owned its business strategy, the characteristics suggest a command and control structure.

2.4.6 Command and Control

Ensuring that the IAPT programme would be credible through a commitment to evidence-based, medicalised, nationally consistent practice requires a commitment to centralised oversight. IAPT is administrated and managed using a centralised, top down, managerial approach – in short, a command and control managerial model. Command and control management systems are recognisable as top down, mechanical systems premised by a stable, orderly, rational operating environment – control and predictability is key to success. However, its limitations can be detrimental to the quality of employee relationships, loss of valuable skills, experience, and innovation, along with a lack of flexibility and ability to adapt (Gorod, Hallo & Nguyen, 2018). Amongst its other limitations are: functional design, as opposed to reacting to demand, flow, and value; decision making being separated from – not integrated into – the work; measurement being budget related, focussed on output, targets and standards – rather than capability, related to purpose; a fixed contractual attitude to customers; change being reactive – rather than adaptive; employees being focussed on meeting imposed measures – rather than customer need (Seddon, 2003, pp.10-11). However, Tsai & Beverton (2007) found that the ability to specify and control desired outcomes whilst, having a workforce that follows instructions (without the need to tolerate ambiguity in their workplace) can be advantageous in the avoidance of chaos during change processes – such as the national implementation of IAPT. Having a workforce that follows instructions may not reflect the idiographic ideology and independent qualities of counsellors; perhaps reflected in the findings chapter by participants of this study. However, command and control ensures that the IAPT programme is adhered to and provides the data completeness that enables IAPT to continually justify its original arguments, and the public

investment in Layard's vision. Key to that vision was the claim that the programme would be self-funding.

2.4.7 The cost of IAPT

A common aspect, or perhaps strategy of the Layard-Clark literature is to repeatedly outline the general history of IAPT, and then present positive findings supportive of the programme and its self-determined success. Clark, detours from this repetitive approach in a later paper, offering insight into a previously undisclosed element of the wider IAPT strategy. Having been honoured by the Canadian Psychological Association, Clark (2013, p.15) reflects on adopting the pharmaceutical industry's development and marketing tactics of, "investing enormous sums of money on lobbying the medical profession to ensure that the drug is widely used". Clark claims that IAPT replicated this approach, leveraging the medical gold standard of RCT in psychological studies to promote CBT as the initial (and continuing) focus for the programme, ensuring that the drug was used. However, the investment of enormous sums of government money was predicated on the claim that IAPT would pay for itself. Layard, Clark, Knapp, & Mayraz (2007) address the costs of IAPT, making the audacious claim (in true Layard style) that IAPT would be self-funding and costs would be recovered in two years – and certainly five years. Repeating the predictable and emotive rhetoric on mental health and the failure of the NHS to conform to NICE guidance on the provision of CBT the claim is made that, "The cost to the government would be fully covered by the savings in incapacity benefits and extra taxes that result from more people being able to work" (p.90). Utilising data from previous RCT studies the paper posits that CBT results can be replicated outside of trials when employed in practice. The effect of unemployment on mental health also is considered, along with value benefits of returning people to work, to the NHS, the exchequer, and a reduction in suffering. The paper concludes by highlighting the £750 per month of a person claiming invalidity benefits is the same as the one-off cost of £750 pm of treatment. Oddly, in a later paper Layard and Clark (2015) advance the same

arguments, to an international audience, in an effort to convince that more psychological therapies would cost nothing, reducing without explanation, the cost to £650. The cost benefits of IAPT presented by Layard have, with retrospection, been robustly assessed. Radhakrishnan et al, (2013) found favourable comparison with initial estimates of costs, but questioned these results if broader costs, such as medication, travel, and loss of income from attendance at treatment were considered. Griffiths and Steen (2013), analysing historical IAPT data, question accuracy of estimations of cost versus actual session provision cost. Mukuria et al, (2013) found probable initial cost effectiveness, but considerable uncertainty surrounding ongoing costs and outcome differences. The current cost of IAPT in financial terms has not been published, the cost in terms of counsellor professional development has never been assessed.

2.4.8 IAPT Professional Development

In 2012, IAPT outlined several accreditation requirements for therapeutic modalities that it supported (IAPT, 2012) through the provision of training in numerous approaches; Low Intensity CBT and High Intensity CBT, Brief Dynamic Psychotherapy, developed as Dynamic Interpersonal Therapy for Depression (DIT), Counselling for Depression (CfD), Interpersonal Psychotherapy (IPT), and Behavioural Couple Therapy, developed as Couple Therapy for Depression (CTD). Accreditation to professional bodies being a required outcome, was facilitated through the training. Consideration of generic accreditation, which counsellors achieve through their own professional associations, was not recognised. IAPT training is geared to the production of practitioners trained in the use of nomothetic modalities, such as CBT, CfD, DIT, IPT and CTD. Layard and Clark (2015) credit this training as having improved the mental health situation in England, with 50% recovery rates and significant improvement in symptoms for others. Whilst Layard and Clark claim that EBT are more effective than medication, others may conclude that such claims are partisan, agreeing with Pilgrim (2011), who suggested a different perspective; one of rhetorical manipulation applied

to the benefit of manualised therapies – particularly CBT. The nomothetic stance of IAPT manualised training may challenge the idiographic nature of a counsellor's practice, not just at a therapeutic level, but with regards to the counsellor's professional self-esteem – a key aspect of counsellor development (Hogan, 1964; Stoltenberg & Delworth, 1987; Worthington, 1987). An unacknowledged theme, latent within the literature, is the subject of professional development opportunity for counsellors in IAPT. The professional development on offer is IAPT-centric and therefore directed at nomothetic approaches developed by IAPT, for IAPT. Counsellors in ideological conflict have no room, on the review of literature, to negotiate on professional development provision.

Making sense of the IAPT programme is a task that belies its claim to be transparent. However, a revised IAPT manual of operations (NCCMH, 2019) has been published to enable commissioners, managers, and clinicians to expand services, maintain quality and ensure effective and compassionate care. This document outlines the IAPT model in great detail. Summarising conditions treated by IAPT, dealing with workforce issues of quality and competence, staff wellbeing, retention, and the responsibility for clinicians to collect data. The document describes issues on assessment and treatment, devotes a chapter to the subject of data and informatics, national standards, national and local reporting, improving access, improving results and many other subjects that may be viewed as a central policy maker wish list, or a helpful reference manual. The central message is organisationally focussed, one of improvement and growth. There is no suggestion that IAPT is for a change of ideology. In the twelve years of IAPT supported literature there has been little evidence of criticality and this document underlines that commitment to its self-belief. However, there may appear to be a conciliatory essence to the IAPT stance on EBT that may offer counsellors some encouragement. Despite having argued the mass benefits of EBT (Clark, 2018), in this document Clark introduces the phrase 'empirically supported treatments' alongside 'evidence-based practice', this raises the question of how the two differ and what

that difference presages of a future IAPT. In the context of this study there is a difference between the two; that which constitutes evidence is determined by NICE, the gold standard being RCT's, prejudicing the qualitative base upon which much of counselling research is founded. However, that which is empirically supported has the backing of analytical observation. In the case of IAPT clinical outcome data this would admit counselling clinical outcomes to empirical support. Empirically supported practice, as demonstrated in IAPT data outcomes, contributes to NICE decisions on what is evidence, encompassing the success of counselling provision in IAPT. Through this logic, counselling (as known in IAPT) may be argued to be evidence-based practice – thereby (intentionally or unintentionally) breaching the treatment paradigm. Clark continues with the IAPT marketing strategy, emphasizing the history and development of IAPT. This strategy, recognisable in all IAPT literature, could be reflective of a continuous pre-emptive validation of the treatment paradigm – if it is published enough times it must be true. Irrespective, a compelling argument is made, based on IAPT data, for its success, and a surprising recognition that counselling, at 10%, is the second most delivered therapy at high intensity, behind CBT at 20%. In realising the mass public benefits of evidence-based therapies – and whilst not championing counselling – Clark implies that counselling has a contribution to make to the further development of IAPT. Previous observation by Jackson (2016) argued, that counselling had stabilised as representing 20% of the IAPT workforce and that mediocre recovery figures were encouraging more focus on NICE compliance, rather than exploring what else could contribute to outcome. Jackson highlighting that IAPT data was supportive of counselling in IAPT, but that NICE guidance did not (currently) support counselling.

Clark, Canvin, Green, Layard, Pilling, and Janecka (2018) assess the variability of clinical performance across IAPT services in England. The need for and development of IAPT is made in the early stages of this paper. The authors continue to consider the variance of outcomes across IAPT services in England. As with all IAPT literature a compelling case is

made for the commitment to clinical data collection and completion, in order that NHS Digital can analyse outcomes. Interestingly, clinical approach and delivery are not held accountable for variation, suggesting that clinical approaches used (including counselling) are efficacious. Local organisational factors are concluded as being a key variant in terms of successful outcomes. In short clinical leadership and management are encouraged to: recognise problem descriptors and match to NICE recommended treatments; establish and maintain short wait times into treatment, to improve service user enthusiasm; increase the number of treatment sessions to improve outcomes; and commit to data completion.

2.4.9 Literature on Counsellors in IAPT

In both the foregoing papers, there is no comparison with external PCMH or common (non-NHS) psychological treatment services, the data is IAPT produced and therefore introspective. As with all the IAPT produced literature it appears to be self-fulfilling, self-validating, with no consideration of options outside of the IAPT treatment paradigm. It is with this in mind, and in that context that counsellor's professional development needs are situated in IAPT. There is a lack of research literature on counsellors in IAPT. Lewis (2012) was conscious of the disgruntlement of non-IAPT therapists perceiving that evidence-based CBT practitioners were, and still are, favoured above counsellors within IAPT. Altson, Lowenthal, Gaitanidis and Thomas (2015) explore implications for non-IAPT therapists in IAPT, referencing the lack of qualitative research available on counsellors in IAPT, they seek to add to the literature, but do not address professional development. Exploring issues using discourse analysis, they identify several categories of contention such as professional, institutional, and scientific approach. This study identifies behaviours (reflective of issues observed in this study) amongst non-IAPT trained therapists, such as feeling as if they don't fit in, and resistance to the IAPT programme. Alternatively, Liness, Lea, Nestler, Parker and Clark (2018) studied IAPT trained CBT therapists, who were observed to enjoy a fulfilling

experience of IAPT employment, evidencing 79% remaining in IAPT employment, 61% training as supervisors, and 23% progressing into senior roles. Such findings suggest that IAPT professional development opportunities favour those employees it was designed to accommodate.

2.5 Summary

This literature review has aimed to critically appraise the literature, from IAPT and non-IAPT sources, relevant to the thesis aim of understanding the professional development implications for counsellors working in the English IAPT programme. It has drawn together topics across a range of disciplines, such as defining counselling, counselling professional development, and understanding the presence and relevance of IAPT in the PCMH system of England. Literature related to these main issues – such as responses to change, frustration, and managerial approaches have been integrated to help contextualise the research question and link them to counsellors professional development implications in IAPT. The next stage of the Thesis is to engage in the research question, beginning with the methodology employed.

Chapter 3: METHODOLOGY

3.1 Research Question and Aims

In this Chapter, the research methods and methodological choices used in this study will be described. The research question that underpins this thesis is: *What are the professional development implications for Counsellors who have worked in the English Improving Access to Psychological Therapies (IAPT) programme?* The overarching aim of this study is broad and explicit in the research question. However, the exploration of that question promotes a number of subordinate aims:

- To explore the degree to which counsellors engage with opportunities for professional development in IAPT service.
- To explore how facilitative [if at all] IAPT service is to the professional development of counsellors.
- To examine how counsellors, conceptualise and respond to the professional development opportunities available from IAPT.

3.1.1 Relationship Between Ontology, Epistemology and Methodology

Ontologically, I place myself in the category of Realism; in that I believe that the material universe is real and that my understanding of the universe is a subjective mental phenomenon. Epistemologically, I place myself in the category of Critical Realism which I can inhabit comfortably. The universe exists in a material sense, independently of my awareness and understanding of it, and I strive (at times) to get as close as possible to that real universe – but I never will because my mind is an instrument that interprets data and decides what it means to me at that time. This can change, not just through social interaction (social interaction providing a harvest of sensory data), arguably just another form of

observation. Therefore, I consider real to be independent of my awareness, beyond which is my epistemological position of critical realism (Ormston, Spencer, Barnard, & Snape, 2014). So, the world exists beyond our control or influence, our understanding of the world is fed through our interpretation of the sensory data which we receive through sensory organs. That data is subjectively analysed and compared within our frame of reference to previous experiences; though contribution from, and consideration of other people's experiences can affect that frame of reference. At this point in my understanding of epistemology I feel it is important to reference my stance on social constructivism, and constructionism. Whatever input external actors have on my knowledge (through sharing it via my sensory organs), it must stand the test of my ultimate interpretation to create my own reality. Therefore, I take the epistemological stance of critical realism above all – but not discounting the value of other epistemological stances. By way of analogy, I am a person with colour perception disabilities, my eyes take in light, my mind analyses that light and attributes a colour to the objects from which that light is reflected. I am often told by others that an object is red when I believe it to be green. I take the view and tolerate the reality that it is red to them and green to me. This diversity of reality demonstrates critical realism for me. I have learnt to tolerate that difference in reality, it serves me as a practitioner of psychological therapy, it is at the heart of my scepticism towards realism as a researcher – my stance on what is truth. It informs my position on knowledge, on evidence. The anarchic beauty of critical realism allows me to be myself, to occupy my own reality for as long as my beliefs and values are in accord, giving me the freedom to seek greater understanding of what real can be. On the subject of realism, I discount subtle realism on the basis that I believe that reality cannot be known only through the human mind (Blaikie, 2007), as I have observed that many non-human creatures (mammals, insects, aquatics) are sensate and have the ability to communicate, therefore the existence of external reality can also be known to them; plants respond to external stimulus, arguably real can be known to more than the human mind. By adopting a robust and consistent methodology of thematic analysis my aim is to demonstrate how I formed my reality (relative to this thesis), but not to convince the reader that it is true.

I would therefore caution the reader to consider that my processing, though subject to refinement in education, testing in examination, generalisation in theory, language, and the socialisation of academia, is most likely limited - and that that is tolerable. So, ontologically and epistemologically, I will know what I know at the time – always what I know, perhaps influenced by what others share with me – a critical realist. Believing that the implications for the professional development of counsellors in IAPT can be known, I will use the structure and transparency of applied thematic analysis (ATA) as a methodology to demonstrate how I came to know what I know, but from that point forward it will be what you know. It is from this ontological and epistemological perspective that my study is conducted.

3.1.2 Relating the Above to the Aims of the Thesis

From an epistemological perspective thematic analysis will allow me to explore these questions through a qualitative interview process, during which I can gather knowledge, and later analyse and develop codes and themes that reflect the participants experiences, and perhaps recognise similarity.

3.1.3 Research Design

I feel it is important to explain that this study was originally designed to be a mixed methods approach (see appendix participants info). That changed, and the study continued in the method of a qualitative ATA only. By way of explanation, the study was originally designed as an exploratory, sequentially designed, mixed methods study (Cresswell & Plano Clark, 2007 pp.75-77). The purpose of this design was, in line with the research question, to explore the professional development implications for Counsellors working in the English IAPT programme**.** The first phase of the study was designed as a thematic analysis (encapsulating the above aims) utilising a qualitative exploration of participants experiences

of professional development implications whilst working in IAPT. This would also include the participants experiences post-IAPT in order to capture contributions – both positive and negative – to professional development on reflection and having left IAPT. The second phase would encompass the design of a quantitative questionnaire, informed by and testing the findings of the qualitative phase. This second phase was aimed at testing the phase one findings against a larger population, and that the meaning of the phase one study would be supported by a mean from the phase two study.

At the outset of planning this study – whilst employing a mixed methods approach – I sought a methodology that would facilitate the epistemological demands of both an interpretive and positivist readership. I was seeking mixed methods as a means of satisfying my need for structure, transparency and predictability. These are qualities that help me to feel secure in all aspects of my life. However, I had awareness of the epistemological tension between positivism and interpretivism, particularly in the social sciences. I identified ATA as an approach to methodology that could assist me in, "trying to understand and explain the world [as related to counsellors' professional development in IAPT] in a rigorous, reliable, and valid fashion" (Guest, MacQueen, & Namey, 2012, p.12). Navigating the tension between these two opposing fundamental aspects of, positivism; basing analysis on a direct consequence of data observation, demonstrating transparency and systematic data collection processes in the reduction of narrative to codes. Whilst accommodating interpretivism; being a subjective interpretation of the social and political meaning from the data, which of itself is highly interpretive (Guest, MacQueen, & Namey, 2012, pp.14-15) required a method that facilitated tolerance of these opposing concepts. On the subject of qualitative research, I was confident in my commitment to those strategies and practices that demonstrate the application of validity and reliability. Thereby, mitigating against outcomes being too subjective an interpretation. Guest, Namey and MacQueen (2012, pp. 83-85) explore the application of those concepts to qualitative enquiry. Discussing the definition of those concepts, they

critically appraise the beliefs that some researchers observe that the terms vary by methodological discipline, whilst others argue that these terms are related to quantitative study, and have no value in the qualitative tradition. It was apparent to me that terminology, the use of words such as validity, reliability, trustworthiness and confirmability etc., can become academically pedantic, obstructing what I seek to achieve – that the reader can trust me and my methods in seeking to explore and understand. In seeking to demonstrate this quality, and to reinforce 'validity and trustworthiness' throughout the process of the research, I kept reflective notes and diaries, which I was able to share with peers during one to one discussion; during group discussions at monthly post graduate researcher meetings; and in regular academic supervision sessions. University of Chester hosts an annual Post Graduate Researcher conference at which I presented progress and early findings on three occasions - all of these methods leading to peer and supervisory feedback, discussion, and further personal reflection. These activities and commitments align with recommendations for good practice in qualitative research, and led to the following key decision in the process.

Whilst undertaking the qualitative aspect of the research, two things became clear through the commitment to those good practices highlighted above: Primarily, personal reflection, and peer feedback contributed to my realising that the data was offering a rich bounty, which required that I do justice to, and respect the commitment of the participants to my interest; secondly, it raised a question as to whether a mixed methods approach was appropriate to the scope and limits of this single researcher, limited funds, and researcher availability to the research task. A further consideration arose from a discussion with my academic supervisor. I was challenged to consider my motives for choosing a mixed methods approach. It became obvious that I was responding to seven years of institutionalised conditioning from the very organisation I was studying (IAPT), accepting positivist epistemological values as a means of validating my qualitative research. I was being drawn into the belief that quantitative enquiry is more valid that qualitative, and that findings would be more acceptable as

evidence to IAPT protagonists based on the IAPT epistemological reliance on quantitative outcomes. Ironically, this realisation could be considered as an implication for my own professional development (having served in IAPT). Having reconsidered this element of my decision making, I reverted to a qualitative approach abandoning the quantitative enquiry and trusting my epistemological values and beliefs. In this regard I was struck by the explanation of Saldana (2016, p.10), “Quantitative analysis calculates the mean. Qualitative analysis calculates meaning”. It is meaning that I sought. However, the ATA process was underway and was (positivistically leaning or not) efficient and facilitative of the study, with the added bonus of reflecting the openness and trustworthiness essential to my values and the demands of the qualitative tradition.

3.1.4 Research Strategy

I was aware that in seeking to answer my research question, analysis of the data would be influenced by my lived experience of IAPT. This suggests a deductive approach, but also that my interaction with the participants and their data would also suggest an inductive approach. I considered a reductive strategy but dismissed this on account of my not working to a hypothesis, and abductive strategy on account of my not seeking to develop a theory to be tested. I therefore satisfied myself that the deductive and inductive aspects of my analytical work can exist together and that the employment of a coding strategy, with explicit guidance in the codes, would serve to balance my challenge to ensure that the research strategy (facilitative of inductive and deductive) would not be confused.

3.1.5 Applied Thematic Analysis (ATA)

I have extensive lived experience, and knowledge of working as a practitioner and manager in IAPT services. The search for meaning within this lived experience and knowledge was of key personal interest to me – giving purpose to this study – particularly in relation to

professional development. It was a driver for the analytical autoethnology (AA) study undertaken by me prior to this study (Mason & Reeves, 2018). When considering methodological approaches to this research and wanting to build on my understand as developed in the aforementioned paper, I considered utilising other (more objective) approaches suitable for qualitative enquiry. Not seeking to undertake a similar exploration of counsellor's experience and understanding of their experience of IAPT, I dismissed using Interpretative Phenomenological Analysis (IPA)**.** Similarly, there was no intention to explore the social processes inherent in relation to counsellors in IAPT with a view to identifying theory, and so Grounded Theory was not considered. Thematic Analysis goes beyond the counting and repetition of words and phrases that corelate to each other, seeking out explicit and implicit meaning from the data to illuminate themes (Guest, MacQueen, & Namey 2012, p.10). McLeod (2015) states that qualitative thematic analysis demands consideration of the projected outcomes, along with a summary of the analytical processes and methodology employed to achieve those outcomes, these qualities of process are important to me. At this stage of my development as an academic researcher I am aware of the limitations of my confidence, relative to developmental stage. It is for this reason that I sought to find a process whereby I could adopt structure, but still remain true to my qualitative values of understanding the phenomena that I observe – rather than reducing it to a statistical mean. I was drawn to ATA as a means of basing this study in a clear and deliverable method of understanding, but also as a means of providing a foundation to my understanding of IAPT for future research topics.

Ryan and Bernard (2000) argue that Thematic Analysis is a process encompassed within analysis on a general basis. Holloway and Todres (2003) take a similar view, in that it is a foundational method of qualitative research, outlining three approaches for which it can provide such foundation: Phenomenology – clarifying whole and part meanings through moving back and forth between the two; Grounded Theory – creating a plausible theory,

using organised data to provide for conceptual patterns, categories and codes; and Ethnography – searching for the building blocks of culture and themes through coding and patterns. Braun & Clarke (2006) argue that thematic analysis is a method in its own right as being a process of identification, analysis, and reporting of patterns within data. Yet the wide use of thematic analysis in qualitative study, and the attribution of brands to the distinct approaches can confuse methodological matters. The adoption of Thematic Analysis as an unbranded approach resonates with the pluralistic nature of the researcher in this study. In essence, the researcher believes that data within this study has been exposed to a transparent process of analysis with the aim of observing commonality in recurring themes, within each participants data set, and across the eight individual participant data sets. The analytical dimensions suggested by Holloway and Todres, being reflective of analytical dimensions sought – but not branded to any particular approach – across this study. The key advice given by Braun and Clark, is that researchers should be clear about what assumptions guided the analysis, to facilitate evaluation of the process. Attride-Stirling (2001) recognises a lack of appropriate tools or methods, with which to analyse qualitative data – the how of analysis. Recognising that without method and understanding of how meaning was attributed, future researchers may be impeded in comparison and synthesis of findings in related studies. In order to address this point, I have set out to explain the how in explicit detail. I will describe the process and avail the reader of the code book used (Appendix. 6) in order that, not only future researchers but also, readers of the manuscript can understand the how of this thematic analysis.

3.1.6 The Applied Aspect of Applied Thematic Analysis

Namey, MacQueen and Guest (2012, pp.12-13) consider the term *applied* in the approach – arguing the focus is on understanding the world in order to inform problems of a practical nature. ATA provides a rigorous, reliable and valid approach to the researcher's quest of understanding and explaining the implications for counsellor's professional development in

IAPT service, using data that has been collected systematically, with transparency, and with an analytical rigour that conforms to those qualities. Whilst ATA is focussed on inductive analysis, I question the validity of purely inductive analysis in any subject area of which a researcher has knowledge. Particularly, with respect to the researchers lived experience of IAPT service.

3.2 Data Analysis

3.2.1 The How of the Analysis

The data analysis process used was an Exploratory Analysis. Guest, MacQueen and Namey (2012, pp. 36-37) discuss the use of exploratory analysis, naming it as a classic content-driven approach, placing the "emphasis … on what emerges from the interaction between researcher and respondent. The content of that interaction drives the development of codes and the identification of themes"; thereby justifying its use in this study. To assist the development of those codes and themes, and to improve on validity, a structured codebook was developed, using explicit notes to guide when a particular code was linked to the data, or not to be linked to the data. Whilst, the use of a structured codebook is often used in qualitative studies with multiple coders, I felt it had value in this single researcher-coder study. Boasting transparency in the approach requires the demonstration of that transparency, and so the process of analysis is worthy of explanation (basic though that may seem). Having collected the data through eight digitally recorded semi-structured interviews, I commissioned the transcription of those interviews. On receipt of transcripts, I checked and edited the recordings against the transcripted narrative. An extract example is offered (Appendix. 2). Detailing the 'How' of the analysis accords with the advice given by Attride-Stirling (2001), Braun and Clark (2006), and Guest, Namey and MacQueen (2012).

3.2.2 Stage One

This process (stage one) enabled me to quality control the work of transcription, whilst immersing myself in the data through reflection on the recorded interview, attending to grammatical rigour, making early observational, and analytical notes. Below is a comment made by a participant early in the interview,

> Prior to IAPT, I think the counselling was a lot of open-ended counselling. So, in some of the services – certainly with school – it's more open-ended (P03)

This was the comment noted by me in response,

> Was not used to working in a structured way, with set targets and session lengths (Researcher Comment)

3.2.3 Stage Two

A second stage of analysis followed, during which I refined my understanding of the data, considered aspects of meaning and what the narrative was sharing in terms of phenomenon. At this stage the formation of codes and themes was developing,

> I'm pleased to say that I don't feel bitter anymore (P02)

This is the observational and analytical note made in response, by me, demonstrating the inductive aspect of the data analysis, the consideration of deeper meaning, and the development of codes,

> Doesn't sound [an interpretation of the participants tone] like she isn't bitter any more to me! But an acknowledgement that she WAS bitter. I wonder whether a BITTERNESS or RESENTMENT code is worthwhile? (Researcher Comment)

Formulating codes is variously described as identifying narrative that simply means, or suggests something (Ryan and Bertrand, 2003; Saldana, 2016).

3.2.4 Stage three

Having undertaken the extraction of narrative to provide data extracts that could be coded and placed within the categories of developing themes, I began developing the code book, including allocation of codes to data extracts. Corbin and Strauss (2015, p. 219) offer the following advice in coding, "the best approach to coding is to relax and let your mind and intuition work for you". The benefit of the code book is to offer the reader an insight into that mind and intuition. Below is an example of a participant interview data extract,

> I also did a short cognitive behavioural certificate within the NHS, but not with them [IAPT]. I paid for that myself. I learned the techniques (P02)

This narrative suggested a number of meanings me: that the participant had engaged with professional development – relevant to IAPT; that this professional development had not been supported by IAPT; that the participant had chosen to invest in themselves; that the participant as empowered; that change was valued by the participant. It suggested and was allocated the following codes:

AGENCY-ACTIVE

BELIEF-SELF-POSITIVE

CHANGE-ACTION

An example of the guidance I created for codes appears below for the code of AGENCY-ACTIVE,

> There are examples during narrative of counsellors describing active attitudes and behaviours towards their professional development. Agency is the capacity of an actor to act in a given environment. In this study, an agent can be described as a counsellor engaging with the social structure i.e. the IAPT programme and its professional development opportunities and structures

I created guidance for when to use this code,

> Use this code when participants take an active role in decision making about CPD or opportunities regarding professional development. This may relate to accepting training opportunities or declining for professional or personal reasons

I created guidance for when not to use this code,

> Do not use this code when data suggests that the participant has not demonstrated an active stance to professional development

Having recognised recurring or connected phenomena within and across participants transcripts, I created codes that assigned a summative word or short phrase capturing the essence of what was being observed and described by the participants (Saldana, 2016, p.4). These codes were then applied to a structural coding process. I created an excel spreadsheet that encompassed all of the guidance and process for analysis (Appendix. 6), including a code name; a brief definition of the code comprising a short phrase; a full definition that describes the context and understanding of the code relative to the study; information on when and when not to use the code; and an example of a data extract or narrative that exemplifies the code. The purpose of this process was to support subjective understanding and analytical decision making for any analyst. Maintaining a code book provided a structure from which to organise and re-organise data, providing a structure for constant comparison within participant data sets and across participant data sets (Saldana, 2016. p.27). Whilst this study was the work of a single analyst (myself), a further benefit is the provision of coding standards available to other researchers in future studies (Namey, MacQueen, & Guest, 2012, pp.52-60; see also Bernard & Ryan, 2010, p.99). The constant comparison process facilitates re-focussing on differences within categories enabling researcher identification of emerging sub-categories, and the identification of categories that do not fit, those categories provide for critical discussion and greater depth to the findings (Willig, 2001). Whilst this detailed and structured approach to analysis may appear unnecessary to some, it was a key and welcome aspect of the design for me. I include this description to impress upon the reader the value I place on structure and transparency.

3.2.5 Coding

My coding strategy was initially influenced by Saldana (2016), who advocates the use of coding for qualitative research. The development of coding books in qualitative analysis is common, moreso in thematic analysis when transparency and trustworthiness is valued (Attride-Stirling, 2001; Guest, MacQueen, & Namey 2012). The use of coding enables the

interpretation of data into meaningful extracts to identify patterns, attribute categories, analyse narrative and develop findings. The individual code, and collective code book, should capture the essence of the meaning in the data extracts (Vogt, Vogt, Gardner, & Haeffeke, 2014, p.13). Silverman (2006, p.101) asks researchers to consider how they might describe what it is they are observing – and thereby coding – as a phenomenon. This question caused me to consider the presence of my deductive knowledge and its effect on the inductive aspect of my analyses. The development and use of a code book would mitigate any conflation of the two, acting as a touchstone in the process, from which I might lessen the prospect of deduction over the observation of fresh perspective. Braun and Clark (2006) consider this aspect of the process of coding, highlighting the difference between coding the whole data set to promote a data driven (inductive) approach to analysis; or being theoretically driven, in which the data set is analysed with a deductive approach to observe and extract those narrative that support a theoretical commitment. In this analysis the presence of a codebook worked well in mitigating the confirmative validation of my lived experiential IAPT knowledge, against the inductive excitement of observing new understandings of phenomena presented by the data itself. In this regard my approach to analysis remains typical of my pluralistic nature, observable in an openness to tolerating the semantic and latent in my analysis. In considering the semantic, a commitment to observing the obvious or explicit, reflected in the obviousness of the final three themes of the analysis (The business, the clinical, and the counsellor's responses relative to IAPT), whilst also remaining open to the latent or interpretive opportunity presented by the narrative to expose underlying meaning; and importantly implications for counsellor professional development.

Having considered ways in which I could construct a code book, I chose to adopt and adapt the example offered by Guest, MacQueen and Namey (2012, pp.55-60). My own interpretation was designed to enable my analysis, and for me to identify the explicit surface, along with the deeper meaning in the narrative extracts – true to my pluralistically

inductive/deductive approach. This convinced me of the value of a structured code book from which, when confused, tired, or over enthusiastic provided a guiding framework for decision making, validation and reflection.

3.3 Sample selection

3.3.1 Inclusion Criteria

Inclusion criteria were counsellors who are not currently employed in IAPT having worked as a Counsellor in IAPT between the years 2008-2016. To include input from as broad as possible a population, no minimum length of service was required. Exclusion criteria were participants who were currently engaged in any form of employment tribunal or civil redress proceedings related to their employment in IAPT as a Counsellor, or currently working in an IAPT service.

3.3.2 Dealing with the Recruitment of Participants – What I Did to Attract and Engage Participants

As described in the literature review, opinions of IAPT can be largely reflective of professional ideology toward treatment, a position that can be generalised along the continuum of nomothetic-pluralistic-idiographic, and so in seeking participants, consideration was given to the inclusion criteria for counsellors. This raised the question of what defines a counsellor? This was dealt with in the study described in the literature review. However, the first task was to identify an applicable definition of what it was that defined counsellors from the perspective of this study. In simple terms, the sample would be drawn from a population of ex-IAPT practitioners who identified as counsellors and worked in an idiographically informed approach, excluding nomothetically informed manualised psychological therapists. In practice, it was discovered that some participants (self-identifying as counsellors) had

availed themselves of the professional development opportunity in IAPT to develop a pluralistic approach which, enabled them to respond to individual service user need; in itself, evidencing professional development derived from IAPT. This dynamic, whilst unforeseen, was an interesting outcome of the methodological strategy, a learning from which I was able to respond and capitalise upon. In this approach, the focus on and use of the term counsellor (as opposed to, say, Psychological Therapist) was a methodological aspect that I discovered to be a limitation and might not use again. Seeking Psychological Therapists who self-identify as Counsellors and adopt an idiographic or pluralistic approach to therapy may have attracted a wider response and would have been more reflective of the population that emerged from the study. The irony being that the purposive population I sought, emerged from the study; more so, than by methodological design.

3.3.3 Finding the Sample Population

Whilst it is the responsibility of each employer to maintain human resource records, there is not standardisation across the English NHS PCMH services. Therefore, records are not kept by IAPT of ex- counsellors, either at NHS England, local NHS Trusts, or IAPT contract holders. Identifying and approaching these organisations with a view to engaging their support in disseminating the study and request for participants was considered and dismissed. A rough calculation of the possible population of counsellors having worked in IAPT services across NHS England since the implementation of IAPT was not reliably possible, although it was considered that a population numbering in the high hundreds would not be unrealistic, given the scale of PCMH services offered. Each of the three services I had experience of working in had varying numbers of counsellors, the pre-IAPT service was staffed by between 20-40 psychological therapists, of which roughly half were counsellors (10-20). Post-IAPT and in different services the numbers declined to between 2 and 8 counsellors, suggesting that there would be more ex-IAPT counsellors than current-IAPT counsellors available to recruit. A strategy of participant self-identification was decided upon.

Using social media, such as LinkedIn, that facilitates groups for mental health professionals i.e. LinkedIn BACP workplace group (6358 members) LinkedIn NHS IAPT professionals (942 members); NHS England Psychological Professionals Network (PPN) counsellor's special interest group. It was expected that these groups would have networks that include or personally know ex-IAPT Counsellors. The response to these requests across LinkedIn groups and PPN generated 18 possible candidates, of which sixteen met the inclusion criteria. Of those not included, one was still serving in IAPT, and the other was an IAPT trained cognitive behavioural therapist with no idiographic training. Of the remaining sixteen, six continued to arrange interviews. The time period across which these interviews took place was slow, running into months. It became clear that attracting participants to the study would be problematic. A further two interested candidates were identified by a previous participant (considered to be snowballing) of which one engaged in the study. Efforts to raise interest in the study included, reaching out to a fellow researcher of an IAPT related study. I was directed to an academic who moderated a counsellor forum. Two further candidates (meeting inclusion criteria) showed interest, one engaged as a participant. Having missed the submission date for a poster at a national conference, I attended the conference networking amongst delegates, sharing details of the study and handing out participant information sheets to interested parties (Appendix. 4), this strategy failed to secure follow-up interest. In terms of finding the study population, it appears that counsellors who have worked in IAPT are difficult to engage in research about IAPT. This would reflect the experience of Altson et al. (2015) in which five participants were involved in the study of current IAPT counsellors who had no IAPT qualifications. Altson also utilised professional networks, word of mouth and email to generate interest, securing five participants. The description of the participant recruitment period of this study, included email, and telephone conversation with candidates, during which the researcher was mindful of the epistemological dynamic of influencing subjects of the study. It was observable, that some candidates I communicated with used an expressive tone, almost cathartic in description – those candidates interestingly did not engage as participants. Having planned a recruitment

strategy focussed on the population considered to have access to the knowledge sought, I was disappointed with the response. It is difficult to understand this response, short of engaging in a further sample to seek feedback, I am aware of related counsellor attitudes to research highlighted by Proctor (2004) who suggests that institutional change towards research attitudes is required. Given the strong ideologically idiographic underpinnings of the counselling professional, the value of generalised or generalisable knowledge may be contributory to avoiding a research friendly culture. Murray (2009) provides a discussion on the *research - practice gap* in counselling, suggesting that counsellors do not seem attracted to the use of research findings in their practice.

3.3.4 Data Collection and Management

Having engaged with the selected sample group, individual, semi-structured interviews were undertaken, recorded using a digital audio device. Interviews lasted between 45 minutes and one hour. The transcripts were prepared through a transcription service. On receipt of the completed transcript, I read the transcript whilst listening to the recording, making grammatical amendments, clarifications, and preliminary notes on analysis. Upon second reading, I adopted a more structured analysis during which time the text was separated into short paragraphs, or unit breaks (Gee, Michaels, & O'Connor, 1992) whenever the narrative appeared to shift in nature. This process facilitated the coding process. Working with multiple participants, I chose to undertake coding and analysis one participant at a time, to encourage recoding of data, and development of the code book.

3.4 Strengths and Limitations of Methodology

3.4.1 Strengths

I believe that the strength of this methodology is its structure, detail, and transparency; allowing for replication if required. Above all, the methodology served to support the aims of this study, in that the collection of recorded interviews is a common aspect of qualitative research, but the process of data collection, management, and analysis is a key aspect of delivering trust in the reader. Trust may not equate to agreement with the researcher's findings, but it will allow the reader to understand how a researcher got to those findings. The approach adopted was influenced by the wisdom of those academics referenced within this chapter, particularly in respect of mitigating any concerns that Thematic Analysis is not a methodology in its own right, but an aspect of those methodologies I chose to forego, such as IPA.

3.4.2 Limitations

A methodological consideration of employing ATA and the adoption of a coding book was facilitative in maintaining objectivity in the analysis stages. I am aware that my lived experience of IAPT placed me in a similar position to an ethnographer studying a social order that they belong to, unaware of the practices that make for the very lived order they seek to illuminate. This is a matter that Pollner and Emerson (2001, p.121) engage, highlighting the methodological problem as, "not one of 'going native' but of already being deeply and naively native". Goode (as cited in Pollner and Emerson, p.131) considers the use of a systematic coded approach to reflect features of social phenomena, cautioning that it may sanitise or distort the lived experience under investigation into a form of data unrecognisable to the participants. I cannot refute any challenge that I might, for the reason

mentioned above, fall into those limitations in this study. I do argue that I have done all I can to mitigate such limitations through the process I have adopted.

3.4.3 Ethical Issues

Ethical approval was sought and gained through the University of Chester ethical approval process (Appendix. 5). Interviews were undertaken (after discussion) at locations favoured by participants, which included suitable accommodation geographically close to the participants in order to reduce time and travel commitment on their behalf. Examples of accommodations were rented third sector treatment rooms (MIND; The Brain Charity) which had a number of advantages, such as participant and researcher safety, comfort (access to facilities i.e. toilets, reception.) and the added bonus of contributing to those charities. Two interviews were undertaken using skype and telephone, all interviews were audio recoded digitally and sent to a University of Chester approved professional transcribing service. Lone working procedures were followed in respect of conducting interviews. All data have been anonymised to protect the identity of the participants; the participants have been allocated codes i.e. Participant 01. All data were stored in accordance with university regulations and the Data Protection Act (2000) and have been kept securely in locked premises or on encrypted computers and/or pen drives. Attention has been given to avoiding harm to participants, to seek their informed consent to engaging in the research (Appendix.3) and to protect their right to withdraw without prejudice (Appendix. 4). In the case of participants experiencing distress or emotional issues, the researcher (an experienced Counsellor) would have either been able to offer and provide support. All participants were qualified and experienced psychological therapists, identifying with the title Counsellor, and members of the BACP. Consideration was given to the researcher's role as 'researcher', and whether at such a point the researcher would enter into a dual role of counsellor-researcher. Whilst this issue did not arise, the researcher was clear in the contracted purpose of the relationship

and any emotional support provided, with signposting to (using the BACP find a therapist web function) a list of therapists in the participant's locality. The research has been conducted according to the principles for best practice, found within the 'Ethical Framework for Researching Counselling and Psychotherapy' (Bond, 2004).

3.4.4 Validity and Reliability

This research has been strongly influenced by the writing of Guest, Namey and MacQueen (2012), who devote a substantially referenced chapter to discussion of the concepts of validity and reliability in qualitative research. In relation to qualitative research and Thematic Analysis in particular they offer no singular list of adherences that can satisfactorily be applied to a study. Willig (2001, p.150), on the subject of validity, states that "qualitative research does not provide the researcher with certainty". Getting close to (but not achieving) certainty is an acknowledgement of my critical realist stance. In seeking opinion and guidance on the subject, one shared theme emerges; that of transparency – findings being reliable, accurate, and credible (McLeod, 1999; Silverman, 2006; Denscombe, 2007). Stiles (1993) broadly offers the explanation that validity and reliability are concerned with trustworthiness. Validity refers to the trustworthiness of the researchers interpretation and conclusions drawn from the data. Reliability refers to procedural trustworthiness, the method by which the researcher observes and handles the data. The abundance of guidance and opinion on the subject of validity and reliability distils to a commitment by myself to demonstrating transparency in the administrative and cognitive process that I have employed in my research, analysis, and subsequent findings from the data. By adopting a structured coding strategy, developing a codebook that is particular to this subject, I have sought to meet the test of validity by engendering trust in my interpretation of the data and the process by which I have drawn my conclusions. In terms of reliability, I believe that the structure and transparency of the code book meets the test of procedural trustworthiness. I

hope that the reader can appreciate that there is a process that I have adhered to, and it is obvious and believable.

The use of the structured coded strategy encompasses more than a claim to validity and reliability through compliance. I have discovered that this process, in itself, requires the demonstration of many of the broad qualities and behaviours outlined in the literature referenced above. Immersion in the data, reflection, constant comparison between observation and category, objectivity – including the recognition of my own lived experience of the subject, descriptive transparency, procedural replication, consistency of transcription, external reference to papers and opinion, definition of terms, multiple sources from multiple sites, the inclusion of the participants through quotations, and a clear audit trail. All these qualities and behaviours contribute to face, and content validity. McLeod (2015, p.100) sums up a set of procedures that enhance credibility in qualitative study, which include "transparency and clarity around the way in which data were analysed … examples of themes and categories … disclosure of relevant aspects of the identity and experience of the researcher". I argue that all of these qualities and criteria are met in this Thesis.

Chapter 4: Findings

4.1 Introduction to The Findings

The Findings have been presented in three separate sections. Each of the following three sections will take the reader through the emergent themes of the business, clinical, and counsellors' responses to IAPT.

Table 1. Table of Themes

Section	Theme	Title
Section 1	Theme 1	The Business of IAPT – How it Might Affect Counsellor Professional Development.
Section 2	Theme 2	The Clinical Aspects of IAPT – How it Might Affect Counsellor Professional Development.
Section 3	Theme 3	The Counsellors Response to IAPT – How it Might Affect Counsellor Professional Development.

With each code, the research aims and objectives

- To explore the degree to which participants engaged with opportunities provided through the business model of IAPT for professional development in IAPT service.
- To explore how facilitative [if at all] the business model of IAPT service was to the professional development of participants.
- To examine how participants conceptualised and responded to the professional development opportunities available from IAPT.

have been considered and addressed, taking a reflexive stance to synthesise and integrate the data from the participant interviews. In relation to the research aims it should be borne in mind that the codes reflected within each theme are interrelated to the research aims.

It is that interrelatedness that allows the codes in this study to come together and separate in no one predictable, or reliable fashion (that would be nomothetic-positivist-real). In this study the participants have experienced, made sense of, and shared their understanding of IAPT and its effect on their professional development. My role has been to analyse those shared observations, initially seeking to identify meaning, which I have coded, and sought to observe further examples of those codes amongst the transcripts of other participant interviews. In doing so, I have observed that it is possible for a participant to express narrative which can be interpreted in a variety of ways; demonstrating that meaning is not an exact science. In that regard I have decided that the codes I have identified are not conclusive, they are representative and can exist alongside each other whilst appearing contradictory. It is best described in quantum mechanics by Bohr's principle of complementarity (Walker, 2000, p.88) in which it holds that objects have complementary properties which cannot be observed or measured simultaneously – in short (I argue) a person can be frustrated and respond as aggressive and resigned at the same time. But we can only observe each response independently i.e. observe the aggressive response and then shift to the resigned response. In the coding of this study, I have used codes, such as those described above, together. Which may suggest that as an analyst I cannot make up my mind between which one is the more real – aggression or resignation. This is not the case, both or all codes can (and do) exist together, can (and do) interrelate, but cannot be observed or measured simultaneously. To demonstrate this phenomenon, I would draw attention to figure 1 below. In this image there are (to my mind) three realities: a sketch of a sophisticated young woman looking away to her right, wearing a fur shoulder garment, a choker necklace, with bouffant hair covered by a flowing feather hat; in the second

observation, an older woman with the same fur shoulder garment, looking pensively forward, she has a long chin, the choker necklace becomes a slashed mouth, she has a prominent nose, and a white shawl covering her black fringe; the final observation is of black and white squiggles that make little sense.

Figure 1. Multiple Realities Image

It is possible to observe three (or perhaps more) images – but not simultaneously. I argue that the nomothetic approach, prioritising one image over another to define reality, is a mechanism that neutralises the challenge of tolerating an uncertain universe, and human nature within that universe. It does work (albeit temporarily) in the relief of uncertainty, but science and history demonstrate repeatedly that opinions change. This process of defining current observation as real might be described through the theory of State Vector Collapse (Walker, 2000, p.94-95). Walker argues that within our universe, at any one moment, there

are unlimited potentialities. In figure 1, theory dictates that the image has unlimited potentialities and that (in the above narrative) I have outlined three of those potentialities. To observe one potentiality (the sophisticated young woman) is to collapse the other two potentialities; making the image - an image of a sophisticated young woman only: thereby discounting the other potentialities. I cannot accept that the application of nomothetic science – the reduction of potentiality, exercising state vector collapse to human psychology as ontologically acceptable. The best choice I can make, at this time in the development of psychology, and related to this study, is to assert an epistemologically critical realist stance. Accepting, that figure 1 demonstrates two images can existing together, complementing each other, but not being capable of simultaneous observation. I argue that, a response from a participant can be interpreted in more than one way. That those interpretations exist together and can be complementary. I would task the reader with considering or tolerating the interrelatedness of the coding applied to the data, how each code can be complementary as opposed to contradictory. Meaning that a participant's frustration needs not be observed as one response, it can be coded as an infinite number of related codes, helping to explain the complexity of emotion experienced in that moment.

A final issue for consideration is that I decided on 64 codes. Thereby, effecting a collapse of the possibilities in the data. There are two reasons I can offer for this, the first being that my mind could not observe any more possibilities. The second being that my analysis required a manageable number of codes, to make sense and provide meaning to that data. In the appendix (Appendix 6) I have presented three tables (one for each theme) that outline the codes that contributed to those themes.

4.2 Theme 1. The Business of IAPT – How it Might Affect Counsellor Professional Development.

This section of the findings chapter seeks to set out how the business model of IAPT might affect counsellor's professional development. When IAPT is viewed through the lens of a business model - originally the IAPT Implementation Plan (2008), and latterly The IAPT Manual (NCCMH, 2019) it has clarity and structure. IAPT exhibits, as its unique selling point, its predictability: a nomothetic ideology; command and control management structure; consistency of training in evidenced based manualised therapies; centralised data collection, analysis, and outcome measurement with national performance standards. These combine to suggest a working environment within which Clinical Commissioning Groups (CCG) can attribute service contracts with a high degree of confidence that their needs will be met. The experience of professional development for counsellors within that structure is the focus of this theme.

4.2.1 Theme 1. Code: Business

The IAPT business model is clearly prescriptive and biased (by design) towards manualised therapy approaches – CBT in particular. This does not facilitate the formal development of counsellors, even if participants were inclined to embrace and adhere to the business model there was a sense that participants had conceptualised a negative bias in the IAPT business model towards counselling, which affected professional development. The following participant, a psychodynamic therapist who had been promised (but did not get) training in DIT, claimed,

> *if you are not a CBT therapist, then there was no way you are actually going to be able to move forward or get any training (P06)*

An issue with the business aspect of IAPT is that it is reliant on CBT therapists to meet its needs (mitigating against investment in counsellor's development). The business model can conflate with and influence the clinical model when changing demands affect business needs i.e. a reduction in wait times or need to meet targets, such as prevalence. Changes such as these in therapeutic delivery affected participants clinical focus. Whilst such practices are arguably an opportunity to learn and develop (by adjusting to shorter treatment demands), they were not recognised as or welcomed by participants. Participants responded to such activity as a trigger for resistance towards an ideologically opposing treatment and business model. One participant, frustrated by this practice, commented,

> *What you were asked to do depended on what target they [management] were needing to meet ... which meant that … there was more of a restriction in terms of the number of sessions you could have (P09)*

4.2.2 Theme 1. Code: Bullying

The business model priorities of IAPT, from a clinical and managerial perspective, can affect decisions made on a day to day basis in services. As a result of such business imperatives, participants shared sentiments that suggested they had conceptualised this behaviour as being forced to work under duress. This was often referenced as intimidation or bullying (see ACAS, 2014). Two participants commented on the effect of outcome measures being used to encourage their focus on the business model needs, rather than client need. This behaviour was evident across services and was perceived as unhelpful to professional development. The following participant shared a sense of being scrutinised, the result of which was to withdraw socially,

I felt that I was under scrutiny, yeah, I did. So, it kind of made me go into my shell a bit (P02)

Another participant, also shared the sense of scrutiny. Of interest in these two comments was the shared use of the word 'scrutiny', neither participant – both mature adult professionals had ever met each other, and yet they had felt scrutinised and shared a sense of intimidation,

I felt quite scrutinised, I wasn't able to sort of develop professionally (P06)

The business model can create an intimidating work environment. This appears to be capable of affecting the relationship between counsellors and IAPT.

4.2.3 Theme 1. Code: Development-Impeded

The IAPT business model is designed to work through manualised nomothetic approaches to therapy. In the IAPT business model, there is no formal professional development available for a classically trained idiographic practitioner. In order to access and succeed in the formal IAPT training, a counsellor would have to be open to flexing their idiographic values and beliefs. Participants felt that this business requirement of offering manualised therapy did not facilitate their professional development needs. One participant summed it up,

I felt limited … like this is as far as I was going to go. You know ... you could almost say there is a glass ceiling for counselling (P03)

To highlight the issue of business need versus counsellors professional development need, it is worth sharing the experience of one participant. In that service the CCG had stipulated that the contract, whilst primarily IAPT, required a local counselling provision. This clause would meet local commissioning need, but conflict with the three key IAPT business principals. In this example the counselling provision was seen by management as an impediment to the business plan,

> *This organisation ... took over the service … but they didn't want the counsellors ... they were ... stuck with them and they have to offer clients, as part of the contract, a choice between CBT therapy and the talking therapy [Counselling] (P06)*

Despite the contractual requirement for counselling, no provision was made for the counsellor's professional development – notwithstanding the existence of IAPT approved DIT, IPT, ECfD. A sense of disappointment, of impediment towards the participant's aspiration to grow, for the benefit of both counsellor and client was shared,

> *I would like to see counsellors and psychological therapists actually be given the opportunities, be offered DIT training, or Counselling for Depression [ECfD], or whatever it is, to enable them to work in the best of their ability for their clients (P06)*

This marginalisation of counselling and embracement of manualised therapies (commonly CBT), was apparent across services experienced by participants. Promoting a perception amongst participants that IAPT development opportunities were biased against counsellors. The concept of the business model, as opposed to personal preference, influencing decision making on professional development was not considered amongst the participants. It

seemed to be conceptualised as a personal construct. In the following extract the participant, whose NHS PCMH service had been taken over by IAPT, uses the terms ‘we’ and ‘they’ as opposed to a recognition of business and strategic imperatives. It was interesting how division had developed in a participant who had worked in that service, after IAPT took implementation,

> *We were separate (Counsellors) they didn't really seem to want us. No, we were not offered that training [IAPT manualised approach] (P15)*

Another participant, similarly in service when IAPT was implemented, shared frustration at the unrealised potential of counsellor’s post-implementation,

> *I could see the potential for so much development and it was always thwarted (P16)*

It is interesting to consider how division appeared after IAPT implementation, when counsellors were already in place and capable of development. It appears that IAPT implementation may have set the scene for continued counsellors impeded development.

4.2.4 Theme 1. Code: Development-Facilitated-Formal

In keeping with the aims of this study, it is worth exploring how participants engaged with, conceptualised, and responded to the opportunity that IAPT does offer to its practitioners as a key aspect of the business model. As stated earlier, from a formal perspective the training is manualised. It is also worth noting that across the study, services did not formally invest in the development of temporary staff. Whilst there is no recognised answer to this, it is

arguable that business requirements would encourage a stable, appropriately trained team of practitioners. Those participants who had engaged with IAPT professional development opportunities were all permanent staff.

One participant had worked on temporary counselling contracts for some years. Permanent employment in IAPT was an aspiration that counselling qualifications was not facilitating. The participant sought to develop a knowledge of CBT approaches. This participant decided to engage with professional development through IAPT, securing permanent employment, whilst qualifying in the IAPT low intensity version of CBT,

> *I wanted to get more insight into CBT [so I secured] a … Psychological Wellbeing Practitioner, course … It's not a counselling course, but it's still a psychological therapy-based course ... that was a useful course to do (P03)*

Training was reportedly not always easy to obtain, despite the availability of, and (particularly in the first 6 years of IAPT) NHS funding for courses. In some services, local policy and business needs might have prioritised particular courses. However, one participant related a successful campaign to access counsellor appropriate formal training, indicating that engagement with the business model could have positive outcomes for professional development,

> *I … petitioned that we could do the ECfD training and that was supported, and we managed to do that (P16)*

The consideration that local business needs, and service policy could affect counsellors engage with professional development was highlighted by one participant,

> *There was like a… CBT wave and then they opened it up to the rest of us who wanted to do the CfD (ECfD) … I did mine in 2013 (P10)*

The above extracts demonstrate that participants, when offered formal IAPT professional development were willing to engage. However, the exception does prove the rule, as one participant shared a strong belief that IAPT training was not desirable,

> *I didn't want what they were offering. They didn't offer much, but I didn't want to be interfered with. I really wanted to carry on doing what I was doing (P15)*

It is surprising that the offer of training to counsellors was not as prevalent as expectations set by reputable publications (IAPT, 2009; DoH, 2008, p.9) would suggest. Local services had business plans that sought to conform to the IAPT Implementation Plan (DoH, 2008) apparently prioritising certain modalities over others. Taking a business perspective, it might be worth considering that for services to perform within NHS England expectations, a service would need to balance the number of staffs engaged in training with those operationally available to meet service user demand.

4.2.5 Theme 1. Code: Development-Facilitated-Informal

The professional development opportunities that are available in IAPT are not confined to the formal delivery of the nomothetically informed, manualised and medicalised approaches

demanded of the business model. There were clear opportunities available on an informal basis – one participant described this development as learning through osmosis – to observe and adopt therapeutic interventions from peers,

> *Working with [and learning from] other therapists that was really the only beneficial thing I have taken away (P06)*

Other participants reported taking advantage of in-service workshops. The following extract is from a participant who valued these ad-hoc workshops,

> *… a talk here and a talk there. So, things like ... a half day working with people on the autistic spectrum ... there was one on medically unexplained symptoms – that was quite helpful (P09)*

Also seen as a means of professional development, was the general practices employed by IAPT services. All the participants referenced the value of being exposed to, conforming to and adopting organisational administrative procedures. This participant highlighted the enduring effect this had had on general development,

> *From a professional point of view, I think it's really helped mould who I am in private practice ... my record keeping ... my general professionalism, has been enhanced by working for IAPT (P02)*

In itself, the experience gained from working in IAPT was conceptualised as valuable, facilitating professional development, and participants engaged with these opportunities. Even the most IAPT critical participants have found informal professional development beneficial from their IAPT experience,

> *As soon as I came out [of IAPT], because I had so much experience – I'd managed to get my accreditation as well ... people come to me, to get me to work for them, EAP's ring me up ... I don't need to do other things to get work, I mean that's been really healing (P04)*

It was clear that all of the participants engaged with opportunity on an informal basis during their IAPT experiences. They found this to be facilitative of their professional development, conceptualising it as non-threatening – for reasons that were not apparent or explored – and responded to it positively. Certainly, there was an aspect of these informal opportunities that appeared less obligatory, and more discretionary from the business perspective.

4.2.6 Theme 1. Code: Ethical

It is arguable that the IAPT business model reflects (but does not overtly own) a utilitarian ethical stance. In simple terms what is best for the majority is prioritised. Whilst participants cited ethical considerations, they also did not own an ethical stance. Participants conceptualising aspects of the business model as unethical and responding with resistance were apparent. There were no examples of participants applying criticality to the ethical issues. In the following extract, a participant expressed strong opposition to the ethical stance without considering the business (or clinical) perspective of what might be ethical,

... it sounds like it's all about me, it's not all about me at all, it's all about the ethics of it ... it's just wrong, and everything about it is wrong (P04)

It is difficult to imagine how such resistance to the business model (on ethical grounds) could attract engagement with the opportunity that such a model offers to professional development, if the counsellor feels it violates their values and beliefs at such a visceral level. The impact of ethical considerations to development attributed to crucial decisions of a personal and professional development nature. Two participants cited ethical struggles as decisive in ending their IAPT service. The first, had reached a stage of intolerance towards the ethical dilemmas of working in IAPT,

(Participant decided to leave IAPT because) It was definitely feeling ... over that four years … that ethically I was being stretched and stretched (P09)

The next participant, had felt compelled to take affirmative action (sadly resigning from post) after receiving no support from a trade union,

My union rep said that they're offering you training ... you can't argue about the job changing because they're offering you training ... I said ... it's an ethical issue for me and it's about my practice, and they said we have no rules about ethics in the union or on employment. If they're offering you re-training, then they're doing what they need to do (P16)

There were clear indications that business ethics were a factor in some participants not engaging with professional development opportunities. In these examples business ethics were conceptualised as unacceptable, and non-facilitative to professional development.

4.2.7 Theme 1. Code: Inequity

IAPT, has a vested and stated interest in professionally developing its practitioners. In particular a focus on training; professionally developing manualised therapists in NICE approved modalities. This supports the business objectives of the IAPT programme. The existence of idiographic (non-manualised) therapists in IAPT presents a dilemma to the business model, particularly when considering the provision of professional development to idiographic practitioners. Participants in this study experienced difference in the way their requests to train were responded to, it was common across services, suggesting that counsellors may experience inequity with regards to opportunity. Whilst counsellors were encouraged from a central perspective to re-train in NICE approved modalities (IAPT, 2008), participants on permanent contracts reported being overlooked when opportunity presented, attributing this to being counsellors,

> *They offered CBT ... companywide, but the only people who were accepted for CBT training were PWPs (P06)*

This was conceptualised as being a negative bias, not facilitative to counsellor's professional development. This inequity also affected those participants employed on non-permanent contracts. The following two extracts highlight the dilemma of participants on temporary contract – seeking permanent employment in IAPT – identifying ECfD training as a means to secure permanent employment and wishing to engage with opportunity. Despite being

valued and contributing positively to their service outcomes, both participants were denied the opportunity,

> *The IAPT service that I worked for … encouraged [permanently employed counsellors] to apply for the counselling for depression training, but it did strike me as odd that they could apply for it, but I couldn't (P09)*

The next participant was clearly made to feel outgroup in the service that did not pay this counsellor a salary, or offer formal training opportunities,

> *No, it wasn't available to me [IAPT training] … I was an outsider really (P02)*

These examples of exclusion to professional development opportunity, on the basis of being counsellors, was conceptualised by the participants as being common across services. The response to this was overwhelmingly to identify with victimhood; struggle with frustration; and a sense of hierarchy in which counsellors were undervalued and unsupported from a professional development perspective, irrespective of employment status,

> *The CBT therapists, the … High Intensity Therapists ... they had the privilege automatically ... they were paid ... on a band seven – we're on a band six – which, I felt was unfair. But in terms of CPD the training was more aimed at them than us (P10)*

Whether these inequities are deliberate bias against counselling or individual counsellors, or factors associated with the business model of IAPT is debateable. However, it is worthy of note that they are observable across services. Counsellors should be aware that such inequity can affect the ability to engage with professional development opportunities in IAPT and that this can be conceptualised as opposing counselling.

4.2.8 Theme 1. Code: Psychological Contracting

The concept of inequity can be nurtured by a sense of promises being violated, whilst other people or groups are privileged. Psychological contracting can play a part in this; referring to a relational process characterised by subjective perceptions that differ between persons i.e. employer and employee; these subjective contracts are dynamic throughout the relationship; contracts are concerned with mutual obligation, based on promises, that benefit both parties (Anderson & Schalk, 1998). Whilst this phenomenon is not unique to IAPT, it is observable through participants in this study. It is worthwhile considering how it might encourage counsellors to engage with the business model in the expectation of professional development opportunity. In this study participants have felt violated through this process. One participant explained how a professional development strategy (or pathway) had formed in their mind, and ultimately not been delivered. This participant reflects on the effect to professional development. It was conceptualised as not facilitating development, hindering engagement with opportunity, and the eventual outcome was to leave IAPT,

> *I probably would still work for IAPT now, had I done, you know, gone along the path that I had kind of anticipated, and been promised to me (P02)*

The process of psychological contracting often began early in the relationship. In the following extract a participant describes the job interview. It is arguable that no formal commitment was made to the participant, but the promise of professional development opportunity appears to have formed in the participants mind. Such an incentive-based relationship might become a determining factor in whether a counsellor engages with the business model opportunities, and can be conceptualised as managerial commitment to their professional development,

> *I spoke to them at the interview, regarding psychodynamic therapy ... about ... still practising in a psychodynamic manner and they said that, yeah, it's absolutely fine … They had DIT training which … it might be a possibility for me to go on ... also counselling for depression (P06)*

Subsequently, the participant was not provided with the training that they expected. This unrealised promise seemed to be an abuse of trust. The choice seemed to reflect a business decision – funding dictating a focus on CBT training – which the participant conceptualised as a violation of the (informal) commitment to their professional development,

> *I wasn't offered any CPD through the company … I approached them [management] to ask if I could attend the DIT training, it was refused because of funding … they were interested in offering CBT training and pushing that forward (P06)*

Business decisions such as these, affecting counsellor professional development, were apparent throughout the participants experiences of IAPT. In the above example the participant did not respond through engagement with opportunities that were on offer at the

time (CBT training), remaining committed to the psychological contract of DIT or ECfD training. The reluctance to engage in training that was on offer – at the time – seemed to be common amongst participants on permanent contracts. This might be attributable to a rejection of, or lack of understanding of the business model of IAPT, or both. However, the role of psychological contracting is worthy of consideration in the process, and how it can contribute to engagement with opportunity; facilitation of professional development; and a counsellor's conceptualisation of, and response to the business model, relative to their professional development.

4.2.9 Theme 1. Code: Workload

Whilst the high volume of caseload and daily sessions offered was referenced by participants, it was not suggested that this differed from their non-counselling colleagues. However, the high volume of workload increased the incidence of complexity and variety of clients that presented. It was interesting to note that none of the participants conceptualised this exposure to severe and enduring mental health presentations as a negative aspect of their IAPT experience. On the contrary, it was conceptualised as facilitative of their professional development, and one that they could and did engage with constructively. The following two participants shared their perception of the positive effect of their engagement with this (perhaps unintended) consequence of the business model. This first participant was working on a volunteer (unpaid) contract,

> *Some of them were very complex [Clients]. I mean, I must say I gained so much experience in that 18 months, I really did (P02)*

The second participant, who worked on bank contracts (NHS zero-hours), had originally been reticent to join IAPT on account of its medical model,

> *There were definitely some benefits to working in IAPT, because ... it gave a good, broad spectrum of people and problems ... I learned a lot from that ... it shaped how I worked (P09)*

In terms of workload, the participants did not suggest that counsellors would be treated any differently to other practitioners. This directly contrasted with the professional development of counsellors. In this respect (workload) IAPT can be viewed as a level, though demanding, playing field. What was notable was the participants perspective of that aspect of the business model, and how it was viewed as a positive contribution to professional development. Conceptualising workload as an opportunity and facilitative, then responding positively was observable amongst all the participants.

4.2.10 Summary

This section of the findings chapter has sought to set out how the business model of IAPT might affect a counsellor's professional development. It has been structured to reflect Theme 1. The Business of IAPT – How it Might Affect Counsellor Professional Development. Utilising the codes that contribute to that theme. In each code the research aims, and objectives have been considered and addressed, taking a reflexive stance to synthesise and integrate the data. The business model creates a difficult workplace environment for counsellors. Decisions are made to support the business, which demands clinical outcome. The provision of, and development of counselling and counsellors is not a business priority.

Counsellors should be aware that the business model of IAPT will present challenges to overcome, but that professional development is possible, if not in terms of a formal provision.

4.3 Theme 2. The Clinical Aspects of IAPT – How it Might Affect Counsellor Professional Development.

This section of the findings chapter seeks to set out how the clinical model of IAPT might affect counsellor's professional development. When IAPT is viewed through the lens of its clinical approach it has clarity, structure, and predictability. NICE guidelines support the approach of diagnosis, formulation, and delivery of an appropriate treatment plan (within the IAPT paradigm) to the issue presented by the service user. Commitment to clinical data collection, analysis, and outcome measurement across services - supported by national performance standards - serve to persuade local CCG that the clinical model is appropriate to local needs. Consistency of training, in evidence- based manualised therapies, is a key attribute of the clinical model. The key issue in this section of the findings is illuminating the degree to which that commitment to the clinical model, with its manualised training and delivery, might affect counsellor's professional development.

4.3.1 Code: Development-Impeded

The IAPT clinical approach is designed to work through manualised nomothetic approaches to therapy. As a result, there is no formal professional development available for a classically trained idiographic practitioner in the business model. The model that IAPT has adopted that most closely accommodates person centred counsellors is ECfD; Psycho-dynamic counsellors are accommodated by DIT; there are similarities within IPT to counselling, as it is a model that developed out of established psychotherapeutic approaches in 1970's North America (Law, 2013, pp. 15-16). These approaches that IAPT offers were found to be

available only to participants working on permanent contracts. However, participants shared that investment in ECfD, DIT and IPT training was limited, in favour of CBT – poorly facilitating counsellor's engagement with formal IAPT training opportunity. Participants conceptualised this focus on CBT as being a major frustration personally, and a lack of interest in their development from the clinical side of IAPT,

> *I approached them [management] to ask if I could attend the DIT training, it was refused … they were interested in offering CBT training and pushing that forward (P06)*

Those working on temporary contracts could not access formal training opportunity. This resulted in them having no opportunity to engage in professional development opportunities and was therefore not facilitative of formal professional development. Inability to engage amongst temporarily contracted participants was conceptualised as being unfair and exclusive. It evoked feelings of sadness, and rejection – leaving the participants feeling disempowered, even used,

> *No. It wasn't available to me [IAPT training] … I was an outsider, really. The management kind of liked having me there, but they kept me at arm's length (P02)*

> *Because I was bank, I couldn't access paid [IAPT] courses that other people were going on (P09)*

It is not just counsellors working in IAPT that can be impeded by the IAPT clinical model. In order to access IAPT compliant training i.e. CBT, IPT, DiT, ECfD, therapists must be sponsored to work within an IAPT service – whilst training. One participant shared being thwarted from engaging with professional development opportunity (at her own cost) after leaving IAPT. The sense of frustration at the exclusivity of IAPT repeats in this participants IAPT experience; feeling that there is a glass ceiling that does not allow access into IAPT for counsellors,

> *Counselling for depression was still being looked at ... when I left ... but you had to ... be sponsored by the NHS to do it. So, as a private practitioner ... I couldn't (P02)*

IAPT services did not seem to recognise that participants deserved counsellor specific training, rather than conversion to IAPT models of therapy. A sense of being overlooked because they were counsellors or seeking counselling specific training was shared by participants from all employment statuses (permanent/fixed term/zero hours/volunteer), even when participants were showing an inclination to engage and develop. One experienced therapist from a person-centred background, having worked on short term contracts in a number of IAPT services, was exasperated by the perceived lack of commitment to counsellor's professional development,

> *Getting the best out of someone's potential is everything that counselling stands for, yet it felt like it was a barrier that existed within IAPT towards myself as a counsellor, and counselling (P03)*

This commitment to belief in the validity and contribution of counselling was mirrored amongst participants. The lack of counsellor appropriate professional development opportunity, of participants offering innovative contribution and commitment, only to be stonewalled was common. One very experienced trainer and practitioner of person-centred approaches, shared a desperate disappointment of the response to counselling engagement and development,

> *I think there was potential there that was unfulfilled. You know, in the same way that CBT do these groups, we could have had counselling groups … You know, probably post one-to-one work, I could see the potential for so much development and it was always thwarted* (*P16)*

This sense of rejection or denial of the value that counsellors had to offer IAPT services, for the want of professional development opportunity, was summed up by one dispirited participant, an experienced counsellor and supervisor who was desperate to add value and find a place for counselling in IAPT,

> *We were separate (Counsellors) they didn't really seem to want us. No, we were not offered that training [IAPT manualised approaches] (P15)*

The irony of participants being engaged on non-permanent contracts, accruing IAPT skills and experience, demonstrating commitment to the clinical cause, but not being included in the national training programmes that would open doors to secure, paid employment was summed up by this participant, who (amongst other qualifications) held a master's degree (MSc) in Counselling Psychology,

it also made me cross that I couldn't get paid work, having worked really hard for 18 months, nearly two years with them. Unpaid working – with step three patients, who can be really quite poorly. And having … pretty good results. I was very well respected amongst my colleagues … some of them didn't even know that I was unpaid

Whilst participants had tried to engage with professional development there were reasons, some contractually based, some based on clinical need, why that was not possible. Participants felt that IAPT had impeded their professional development.

4.3.2 Code: Development-Facilitated-Formal

Facilitated formal professional development in IAPT was only offered to permanent contract holders. A pre-requisite of formal IAPT professional development is that the participants would have had to engage with the IAPT clinical ideology. Some participants conceptualised this as being imposed upon them as opposed to choosing. In the words of one participant there was a resignation to the frustration of having little choice in how the clinical model expected counsellors to respond to the changes,

Well, the priority was ... if you were going to survive … and continue to work as a counsellor, and be paid wages … it was about fitting in to the model (P10)

Another participant, an experienced counsellor with permanent employment status, was open minded with regards to diverse approaches to therapy, but very clear about clinical focus being on client need. Formal training in IPT was a requirement that this participant

engaged with and completed, but seemed clinically superfluous to professional development,

> *It's on my CV [IPT] ... I don't use it ... In terms of my professional development, I left the NHS, so I didn't need it (P06)*

It was interesting to note that some participants, whilst resistant to the IAPT clinical stance, had recognised benefits to their clinical development post training, demonstrating the value of the IAPT professional development on offer to counsellors. An experienced person-centred counsellor, sent on ECfD training with low expectation of benefit, was pleasantly surprised at the outcome,

> *I did enjoy it [ECfD training] and it actually surprised me. I … got more out of it … than I imagined. But really, I went on that to stay employed (P10)*

Another participant, recognised the value of the IAPT training (post-IAPT) in private practise,

> *From my own development … I think it was really useful because now I'm in private practise, I can still use some of those [interventions] for different clients (P06)*

It is arguable, that the participants exposure to IAPT professional development opportunities had an unexpected outcome. Being able to accommodate the requirement to engage with IAPT clinical ideology and benefit from the professional development perspective, could also suggest a developing clinical or ideological pluralism amongst those who had partaken. It

was noticeable that the participants did not evidence conceptualising the notion of pluralistic development in themselves.

One participant made a decisive choice, to apply for a non-idiographic, non-counselling IAPT training position in order to learn more about CBT. This participant had worked on a number of IAPT short-term contracts, hoping for a permanent contract of employment. When the participant realised that such an aspiration was not forthcoming as a counsellor, the strategy of securing a training contract in low intensity CBT was adopted, with a view to permanent future employment and access to formal facilitated professional development. One might consider that this is an example of engaging clinical and ideological pluralism whilst leveraging IAPT opportunity to progress professional development,

> *I wanted to get more insight into CBT [so I secured] a … Psychological Wellbeing Practitioner, course … at university, over the course of a year (P03)*

Along with an awareness of the concept of pluralism amongst participants, the concept of IAPT as an enabler to professional development was not observed. However, the outcome is arguably obvious – IAPT could be conceptualised as a professional development enabler for counsellors. Though ideological and clinical pluralism (or at the very least – flexibility) is required to exploit such an opportunity.

4.3.3 Code: Development-Facilitated-Informal

As mentioned above, access to formal training in IAPT is linked to permanent employment status. However, participants of all employment status appeared to have had equal access to informal professional development opportunity. This section of the findings explores the

coded narrative which relates to the participants experience of working within the clinical model of IAPT. In particular, how informal professional development opportunity could have facilitated their professional development. In this study, informal professional development relates to those local (in-service) training courses, workshop opportunities, and experiential involvement that provides for or contributes to professional development. Workshops and in-service training were referenced by participants, with varied levels of satisfaction. This participant, an experienced IAPT practitioner – due to multiple short-term contracts – recognised a need to engage in a substantial programme of IAPT professional development that would contribute to permanent employment. Whilst grateful for the access to local training, this counsellor was disappointed in the lack of commitment to his aspirations,

> *It was more sort of one-day training, here and there, and I need a long-term training (P03)*

Another participant, working on a zero hours contract, was very grateful to access ad-hoc local training which was conceptualised as an added benefit,

> *within our team meetings, there was free training put on. So, any free training that was put on, I did go and attend … for instance … working with people who may be on the autistic spectrum (P09)*

The ad-hoc, local training was not the only stream of informal opportunity for professional development. Reflection on their experiences of working in the IAPT clinical model provided positive aspects of professional development, for example a broader understanding, acceptance and integration of clinical approaches and practices. This participant, whilst

frustrated with the lack of payment from an honorary contract, recognised the value of the complexity of client presentation in terms of professional development,

> *Some of them were very complex [Clients]. I mean, I must say, I gained so much experience in that 18 months – I really did (P02)*

As suggested in the above extract, the value of experiences was not confined to complexity. Participants shared a broad range of contributions to professional development. The following extracts exemplify a variety of clinical development and experience available from working in IAPT,

> *Things that I've changed in the way that I work. I think my awareness of what it's like to work in short-term settings ... why they [IAPT] use the different measures ... wider use of measures to measure things; for OCD, or for trauma ... I think it was helpful (P03)*

Speaking in more general terms of the benefits of professional development, one participant shared enthusiasm for the clinical challenges; particularly of being able to specialise in working through interpreters, an opportunity which this participant placed a high value on,

> *I loved it, actually ... being able to work with interpreters; never thought I could do that, and I did ... So, I actually got a lot out of that (P10)*

These examples serve to demonstrate the informal value of professional development that can be gained through working in the IAPT clinical model. However, it is also worth noting the personal, physical and emotional costs that come with such clinical exposure. One participant referenced the personal demands of working in the IAPT clinical model, whilst recognising the double-edged value of that experience,

> *I felt it was quite [emotionally and physically] draining, and it was a bit damaging. I can recognise that it has given me some experience, and ... you may not get that experience anywhere else (P09)*

This ambiguity in relation to benefit and non-benefit was subjective in nature, and should be considered. By way of example, one participant, who disclosed ongoing management of physical conditions, shared balanced views on the physical effects of working in such a challenging environment,

> *I mean it's difficult with me though, because you can never say what causes what, can you? but none of that [IAPT working environment] helped my health problems, which are hard enough to deal with anyway, like with any physical health problem, stress is bad for it, isn't it, so there's all that (PO4)*

Arguably, there was also an element (not explicitly owned) of pluralistic development. As in the following extract, a person-centred counsellor who had trained in IPT and CBT, recognised that the exposure to diverse methods had influenced clinical approach across ideological stances of what - in effect – is an ability to shift between idiographic and nomothetic approaches,

But it was useful, because what some of that has given me is a formal integrative model, which is very helpful, so you know, obviously, more tools you got, the better (PO4)

In conclusion, both the below participants (like the others in this study) had had problems with IAPT across the clinical perspective. However, both shared that despite the negatives of IAPT in its clinical sense, IAPT had contributed to their professional development in quite profound ways,

From a professional point of view, I think it's really helped mould who I am in private practice ... my record keeping ... my general professionalism, has been enhanced by working for IAPT (P02)

It has been a challenging journey. It's also been a very developmental one. It has given me insight ... developed me into both the person ... and the therapist I am now (P03)

4.3.4 Code: Employability

There appears to be a paradox to the value of counsellor's professional development in IAPT. As can be observed in the above findings, the clinical model provides for considerable benefit in relation to counsellor professional development; moreso if the counsellor has a permanent contract of employment. Irrespective of employment status, it is apparent that the IAPT clinical model provides valuable informal development, relative and appropriate to the IAPT program. The paradox is that despite participants in this study recognising the value of this development, for non-permanent counsellor's this experience will not enhance

their employability in IAPT. It was observable that, paradoxically, participants who had worked in IAPT were more employable outside of IAPT due to their IAPT developed clinical and administrative skills being held in high regard.

Counsellors have always recognised that there is paid work and unpaid work, and that paid work is at a premium for counsellors. IAPT initially created over 6000 jobs for psychological therapists but made a clear choice to avoid counselling as a modality – and in doing so – invalidate counsellors' employability within the programme. Social workers, occupational therapists and nurses were prioritised over counsellors in the Depression Report (LSE, 2006). Many counsellors were already working in NHS PCMH services prior to implementation, but others (reflected in this study) were employed as counsellors' post-implementation. Employability is a key factor in professional development choice. Participants, who had permanent contracts of employment, shared how the threat to counsellor's employability of not being IAPT compliant affected them. Both of the following extracts were from participants who had been employed as counsellors, on permanent contracts, in services prior to IAPT implementation. Both held strong idiographic stances at that point in their development, and reflected the ideological dilemma placed upon themselves (and colleagues) during implementation to conform to the IAPT nomothetic ideology,

> *We had counsellors who later became CBT therapists because they were frightened for their career (P04)*

> *They [local management] said that I would have a reduction in my hours, and my income, if I didn't attend the [CBT] training (P16)*

The IAPT paradigmatic resolve to replace all options for psychological therapies with nomothetic approaches is reflected in the above extracts. It perhaps adds some meaning to the puzzling inability of counsellors, with non-permanent contracts of employment, to access formal professional development in IAPT. An obvious paradox, in the relationship between IAPT and counselling, is that counsellors are commonly employed in IAPT on non-permanent (paid and unpaid) contracts. This has been ongoing since implementation in 2008. The continued presence of counselling in IAPT demonstrates the value of counselling in PCMH, and the contribution of counselling to the IAPT programme.

Whilst IAPT may conduct a confusing relationship with counselling and its counsellors, the external market for counselling and counsellors values ex-IAPT counsellors highly. Participants shared their experiences of seeking employment outside of IAPT services after having worked in and accrued clinical experience. This participant, irrespective of being highly qualified and having extensive IAPT clinical and administrative experience, could not secure a permanent IAPT contract. Ironically, a non-IAPT NHS service sought this participants services (paid) for the clinical supervision of its own practitioners,

> *I'm an associate with the NHS [not IAPT] now and they pay me to work one to one, with staff, providing clinical supervision (P02)*

Another participant, on leaving permanent IAPT employment for ideological and health related reasons, was inundated with offers of paid employment unrelated to IAPT,

As soon as I came out, because I had so much experience ... people come to me to get me to work for them, EAP's ring me up ... I don't need to do other things to get work (P04)

Both these participants attributed their IAPT clinical knowledge and experience to their enhanced employability,

Well, I don't think I'd have got any paid work if it hadn't been for IAPT. Because it gave me a structure (P02)

I am valued, and … to have people want to employ me, and pay me to do things is wonderful ... I work for all kind of people who think … that I am a good therapist (P04)

The concept of somehow losing the knowledge or ability to apply an idiographic approach post-IAPT, that counsellors might cease to be counsellors was dealt with by one of these participants,

you can't un-know things, can you? I've just learned a way of doing things without losing my … person-centred values (P02)

the concept of clinical pluralism was ever present amongst the participants, its clinical value in responding to diverse clients and presentations was reflected by this participant now in private practice,

From my own development … I think it was really useful because now I'm in private practise, I can still use some of those [interventions] for different clients (P06)

With regards to the participants of this study, the professional development opportunities and value of clinical experience, to the market outside of IAPT was clear. The experience and knowledge accrued in IAPT enhanced employability, or had developed aspects of their professional selves which had contributed to their current abilities to practice therapy, supervise practitioners, or deliver training.

4.3.5 Code: Equality/Inequity

IAPT has been clear about its clinical approach from the outset. However, the presence and contribution of counsellors to IAPT's claimed success over the past 12 years cannot be ignored. A clear implication for counsellors working in IAPT is that there is limited formal professional development opportunity, whilst informal professional development is valuable and available irrespective of approach. Participants shared sentiments of frustration and sadness in this regard, one might even describe elements of pathos regarding the sense of inequality between counselling and IAPT nomothetic approaches to treatment.

The following extracts serve to outline this disappointment. All experienced counsellors, experienced IAPT practitioners, seeking to develop their knowledge and experience and contribute fully to the task of delivering PCMH and to NHS service users. This participant, a vastly experienced PCMH counsellor, was unable to find a way past the clinical dogma,

IAPT took over and ... we were kind of in the way ... we were really surplus to requirements (P15)

This participant, had moved between IAPT services on short term contracts, seeking a place to grow and develop, repeatedly failing to find validation of counselling or commitment to the professional development of counsellors,

If I felt that there was more opportunity and flexibility for counselling, and developing CPD, and training further in the way that I work as a counsellor ... I may feel a little bit more comfortable towards IAPT (P03)

This participant voiced a common perception of the IAPT attitude towards counselling, that CBT remains the privileged and unopposed method of delivering therapy in PCMH,

the CBT therapists got quite a lot of training put forward for them ... they seemed to have more input … I think we were sort of left (P10)

It was not all bad, despite the primacy of CBT, as some services encouraged counsellors to train in ECfD,

The IAPT service that I worked for … counsellors were encouraged to apply for the counselling for depression training (P09)

Clearly, counsellors will experience inequity in IAPT. It is arguable that, with IAPT being the PCMH approach for NHS England, inequity towards counsellors is organisationally acceptable and that counsellors should be grateful for whatever work (paid or otherwise) they can secure in IAPT. Leaving aside the socio-political and clinical arguments of such an assertion, it was clear that counsellors had ethical challenges around the clinical provision of the IAPT model.

4.3.6 Code: Ethical

There is a key aspect of the ethical dilemma presented to counsellors through the clinical model of IAPT. Idiographically located practitioners are focussed on the needs of the individual and their story. Nomothetically located practitioners are focussed on the generalised needs of a population. Arguably, the unacknowledged ethical stance of IAPT is utilitarian – to maximise the positive effect for all affected individuals and in so doing, to apply a manualised approach to psychological therapy. There is a gap between the aspirations of both approaches; it was a gap that participants of this study had struggled to bridge.

From a clinical practice perspective, the participants shared frustration with the ideological; the practical; and the methodological. The following extract relates to the ideological position that service users should be experienced as having unique qualities, that operate individually and which will bring about change at different rates. This challenges the IAPT generalisation of diagnosis, dose, and recovery. The participant spoke from a position of being clinically open-minded, but unable to countenance the strict requirements to complete a course of treatment, in set time scales, across a normative vision of service users,

You're not allowing someone to arrive at their own point of change, and it pushes the … pace within the therapy because of … the need to get someone out the door [discharged] (P03)

Another participant struggled with the practice of constructing a normative reality of peoples distress through psychometric measures. These measures would then dictate type, intensity and model of clinical intervention,

A lot of it [my struggle] was about holding off things that didn't feel ethical. So, one of the big problems ... was the psychometrics that were increasingly imposed on the clients (P04)

Another participant shared a sense of frustration, that individual therapeutic method was continually challenged in favour of a standard manualised approach. Such an approach, replicable across practitioners, caused the participant to question the validity of their own therapeutic model,

It was definitely feeling ... over that four years … that ethically, I was being stretched and stretched, and trying to justify my own integrative-ness (P09)

Counsellors should be aware that there is little flexibility in the IAPT clinical model from an ethical perspective. Participants in this study did not share an openness to (or even awareness) differing aspects of morality and ethics relating to the delivery of psychological

therapies. Amongst the participants, there was a sense that the ethical stance of counselling was the correct stance. This was in direct conflict with the IAPT clinical stance.

4.3.7 Code: Exploitation

Taking advantage of counsellor's clinical skills and knowledge through employment practices, such as fixed-term, zero hours, or volunteer contracts, with a perception that permanent contracts for counsellors will be available at some future time, was common. It seems to be normal, for IAPT management to enable the phenomena known as psychological contracting to develop. This phenomenon encourages or permits informal expectation of future benefit to develop amongst counsellors on such contracts. None of the participants reported, at any time, that management had been clear about the business and clinical imperative to permanently employ practitioners with IAPT approved qualifications. A number of participants had formed a belief that permanent employment would be forthcoming. The following participant, who held a master's degree in counselling psychology, was employed on a volunteer contract to deliver therapy. The permanent role that this participant was encouraged to apply for, and was successful, was as a support worker. The IAPT service then continued to employ this participant in a volunteer counselling role, which served to encourage the participant to believe that the promise of a permanent clinical role would be forthcoming. The following extract speaks for itself of the personal desperation, professional commitment to IAPT, and violated trust experienced by the participant,

> *So, the job never came ... they then asked me to apply for a job as a support worker ... I was desperate for money ... so I applied for it ... equivalent of a band 2 in the NHS ... the clients I'd been working with as a therapist would have been a band 7 or a band 8 therapist in the NHS. I was still doing my counselling work for them … I was*

trying to weave my counselling work in amongst that – which was really, really hard (P02)

Working on temporary contracts, with or without payment, as a counsellor in psychological therapy services is common - and not unique to IAPT - however the volume of temporary counselling provision in IAPT, suggests that demand is high for counselling. As the following participant identifies, there appears to be no shortage of temporary clinical work for counsellors in IAPT. This participant was always seeking that permanent contract, that place to belong and develop – this was not a person who relished a peripatetic work life,

I've ... worked in a lot of different places on short-term placement, and on bank work counselling (P03)

Leveraging hope and expectation, was not the only clinically exploitative aspect of participants experience of IAPT. The complexity and severity of cases was often referenced by participants. Using counselling to treat diagnoses that were outside of NICE guidance and IAPT clinical policy was common. The below extract is from a participant who felt that management encouraged the use of counselling, beyond a level of severity and caseload that was required of a counsellor,

I had my own waiting list that I managed ... I used to work with … severely ... depressed and anxious clients … It was quite tough sometimes because there was a lot of form filling that you needed to do. You needed to make sure the information was on the system … sometimes it was the amount of clients that you had; because

they would expect you to have at least six clients per day – you had three clients in the morning, three in the afternoon (P06)

The below extract shares the sense of professional vulnerability, competence, and doubt invoked by the levels of complexity that was expected of a counsellor. The absence of commitment to counsellor's professional development is implicit in this reflection,

I felt this … would be stretching my experience ... I didn't feel grounded enough to work with somebody of that complexity ... people who ... have got higher levels of training, who are on a higher pay … should be the ones that would be working with that level [of complexity] (P10)

Counsellors should be aware that IAPT service leaders (managerial and clinical) can exploit their clinical knowledge and expertise to meet service needs, whilst not entering into partnership with the counsellor's professional development aspirations.

4.3.8 Code: Growth

Counsellors who have worked in IAPT will often recognise aspects of their service as enabling professional growth, for example, gaining a better understanding of psychiatric, or severe and enduring mental health problems etc. The experience of IAPT service is not always negative, it was not a finding that participants had dismissed all of their IAPT experience as being negative; in fact, it is almost predominantly mixed in its qualities. It may also be, that time away from IAPT enabled participants to see professional growth where previously, they had not.

Participants shared examples of greater psycho-therapeutic insight. In the following extract, a participant with a challenging experience of IAPT reflected on a new perspective that was clinically inclusive,

> *It made me realise that there's room for all different kinds of modalities. You know, not just humanistic, person centred, psychodynamic … there's room for lots of different areas (P02)*

Another participant shared insight on the medical approach to psychological therapies, and how that had expanded outlook,

> *It give me an insight into how different conditions develop for people. So, I found that quite helpful, quite useful (P03)*

The two above participants had originally trained in person-centred approach. Entering IAPT they had idiographic values and approaches. They shared a changed perspective and appreciation of CBT (a nomothetic approach), suggesting that CBT as an approach was valued, and even integrated into their personal model,

> *I'm on with cognitive behavioural approach, which I learned in IAPT (P02)*

> *I don't have a deliberate bias towards counselling, although I like counselling, and I don't have any deliberate value with CBT ... I'm qualified in CBT ... I'm very open to the idea of using other models (P03)*

Another participant had observed the value of CBT in IAPT, and whilst not trained in the model, had adopted techniques into their personal model,

> *I did start to use some CBT techniques – even though I wasn't trained in it. So, in that respect, it did give me some tools that I could use (P06)*

Aside from the clinical applications of IAPT and impact on counsellor's professional development. Participants shared general growth from working in IAPT, in the form of professional and psychotherapeutic confidence,

> *It's had some positive aspects in terms of me understanding and working with people … I think, I understand the different [psychological] conditions really, and understanding of what I do, and what I don't (P03)*

> *I feel even more proud that I survived … not only that, but now I'm thriving, and that I've made success in my own micro business, and I'm making a living (P04)*

The professional growth that participants shared from IAPT went beyond technical, clinical changes. Participants developed a greater resilience, both professional and clinical, a greater confidence in their professional self. This was not always during IAPT service, for some, it had developed post-IAPT. Once more, the ideologically pluralistic influence was apparent; being able to shift clinical approach to suit the client needs.

4.3.9 Ideology

Counsellors are generally trained in, and/or attracted to counselling as a result of its idiographic ideological stance, and often remain attached to that ideological stance. It is questionable whether, and to what degree participants recognised this aspect of their work for what it is, and even whether they understood the theoretical and pragmatic value it has in relation to their profession practice and development. In the findings it was perplexing to observe that participants ideological stance was unreliable, the most reliable (in terms of predicting an idiographic response) were those who had expressed general frustration with IAPT, as opposed to those who expressed specific frustration. It may show that the participants were more inclined towards pluralism, more ideologically flexible, whereas IAPT is fixed in its ideology.

4.3.10 Code: Ideology-Difference

There appeared to be an expectation amongst participants that IAPT would accommodate their ideological stance. Participants, received varied responses to this from their various service management. The presence of ideological difference was palpable, but the awareness of difference being ideological was not explicitly known (or being so, was not shared) by the participants. This was of interest, because it might explain why many counsellors believe that the IAPT stance toward counselling is personal, rather than an example of ideologically based clinical integrity. One participant, employed on a volunteer contract, had sought to gain permanent employment over two years, attributing the lack of success to qualifications,

There was no way in, unless you had a psychology [Nomothetic] background (P02)

Another, expressed exasperation toward IAPT for making no attempts to accommodate and tolerate counselling's ideological values and beliefs,

> *Counsellors have to fit the model of IAPT ... as opposed to IAPT fitting the model of counselling (P03)*

One participant shared having developed a greater understanding of the IAPT ideology. This had enabled this participant to take a more flexible stance, but one that did not conform or fully compromise their own ideological position. It worked, because the participant was exploiting (in gentle terms) IAPT for personal and professional development aims,

> *I got a bit more of an understanding of IAPT, and … I wasn't sure that I did fit within the IAPT box … I didn't leave then for various different reasons … but I thought I don't necessarily want to work that way (P09)*

Ideological differences between counselling and the IAPT approach to therapy can result in conflict or compromise. In order to maximise the opportunity available from a professional development perspective, counsellors should consider the benefits of a more flexible attitude towards clinical ideology.

4.3.11 Code: Ideology-Idiographic

Working as an idiographic therapist presented challenges to professional development when the participant was unable to recognise value in the nomothetic perspective. In each of the following extracts, it is possible to determine frustration, challenge, even a lack of flexibility

between an idiographic (subjective) stance, to a nomothetic (generalised) stance, in order to deliver the manualised, clinical (and business) outcomes required in IAPT. The first extract comes from a participant who had developed pluralistic characteristics. It is interesting to note the implicit confliction this participant is expressing with regards to ideological flexibility,

> *[IAPT is] solely evidence-based, in a hurry to get people in and out of the door, and actually not to work enough for the person's best interest (P03)*

The next participant expresses a clear idiographic stance (focus on the person), irrespective of the IAPT clinical approach (focus on the diagnosis),

> *When I was with a client, my focus is on them, and I'm interested in them, I'm giving the values, the … core conditions and they came naturally (P09)*

In a similar vein, the next participant remained idiographically situated, clearly aware that this was not what IAPT was seeking clinically, but prepared to continue with a focus on the individual,

> *[Management] didn't know what went on in the room, and what you did try and do – in the room – is work with where the client is at, and where they wanted to go, and how they wanted to be (P10)*

Responses to the challenge of meeting the IAPT generalised approach to therapy were idiographically situated. The degree to which the participants applied their idiographic stance

differed. This finding made it difficult to identify a general implication (ironically) across the participants beyond that which suggests that counsellors will make up their own minds about compliance – and that this can have different implications for professional development.

4.3.12 Code: Ideology-Nomothetic

The nomothetic ideological approach adopted by IAPT is best related to as the establishment of generalizations pertaining to all people. The structured delivery of treatments based on these generalizations created opposition in participants. As mentioned in the above section (idiographic) some participants had adopted more pluralistic stances and approaches to therapy, there was common agreement on their opposition to strictly nomothetic practices. One participant, who demonstrated openness to ideological flexibility, shared an opinion that the structured delivery of therapy was predisposed to systems and protocols,

> *I felt like it was having to concentrate on systems as opposed to people at times (P03)*

Another participant, whilst seeking to respect and deliver idiographically situated treatments, shared a struggle with feeling drawn into the more nomothetic approach,

> *I wondered whether I had gone too far the other way (too directive) in that I was coming up with coping mechanisms and strategies, and suggesting that [to the client] (P09)*

The next participant had tolerated clinically based impediments that challenged ideology, but had reached an ideological saturation level with the requirement to adopt and implement clustering - a model designed to accommodate payment by results in the IAPT business model (DoH, 2012) - and was unable to compromise values and beliefs any further,

> *Well, the thing that was the bottom-line for me was the clustering, I wouldn't do that (P16)*

The generalization of people's distresses into diagnoses, to accommodate structured treatment models, was an early issue for all the participants when introduced to IAPT's clinical approach. Some participants were more flexible in their ability to tolerate or adapt to IAPT clinical ideology.

4.3.13 Code: Ideology-Pluralistic

Participants who had adapted from an idiographic position, demonstrated openness to the generalised knowledge of nomothetic approaches. Whilst, pluralism was not explicitly referred to, there was an implicit understanding, and even evidence of pluralistic tendencies developing. This participant, shared an understanding of the value of choice in psychological therapy, implicitly suggesting an ability to deliver (or develop) a broad range of approaches. It is a simple reflection that is difficult to challenge,

> *Obviously, we're a diverse bunch, us human beings, aren't we? You know, what works for one won't work for somebody else (P02)*

Whilst, some participants had objected to and rejected the adoption of nomothetic clinic measures, others had found a middle ground in their use. This participant shared adopting the measures in a pluralistic way, that suited both participant and client,

> *I use the measures in a way … that they can give an indication and ... might flag up something that you could work on, but I'm not going to be a slave to them (P09)*

Whilst, the championing of evidence-based approaches had diminished counselling in IAPT, a number of participants had recognised value in the approach and trained in CBT. An aversion to the CBT model was not apparent, if anything participants were open to diversity of approach. This was exemplified by the following participant, who had read about and considered the value of broadening clinical options,

> *I remember … reading the journals ... about CBT evidence based. So, I thought ... better get some training in that then (P10)*

The participants had varied perceptions of the concept of pluralism. Mostly, participants were open to other clinical approaches. This suggested that counsellors would be open to developing a wider skill set of clinical approaches beyond the idiographic approached they had been originally trained in.

4.3.14 Code: Informatics

Collection, analysis, and dissemination of data in the IAPT programme is a central theme of both business and clinical models. Whilst, the data model is intended to be a clinical tool, it is

also used in the command and control business element to provide evidence of the efficiency of the IAPT program. However, participants experienced the informatics element of IAPT in a variety of contrasting ways, both supportive and punitive. This participant saw value in the client seeing a visual representation of progress through the psychometrics,

> *It's really useful for a client to see that they ... score ... on the depression scale and towards the middle or ... the end of therapy they can actually see it [change] in black and white (P02)*

For others it was anathema. This participant shared a need to apologise to clients for its imposition,

> *I would actually apologise sometimes to people ... because I wouldn't look like I wanted to do it [take psychometrics] ... so I had to say to these people - "I don't really think this is right, but unfortunately this is how the service works now" … they're stealing the [therapeutic] time from these poor people [by asking them to complete psychometrics] (P04)*

Another participant, was appalled by data collection and took the frustration with measures being imposed upon clinical approach a step further. The participant prepared and presented, to management, a case against their use,

The minimum dataset … I was so cross about it. I did a presentation against it … it was symptom based and it wasn't anything to do with the [counselling] therapy that we [counsellors] offer (P16)

Informatics, has a broader meaning to IAPT than just the employment of psychometrics. Learning to use patient management systems was largely seen as being positive. The first participant expressed compliance and tolerance, rather than enthusiasm regarding the requirement to keep notes on a database,

They [IAPT] taught me how to keep electronic notes, which I wasn't very happy about, but that's what you do in the NHS. So, that's fair enough (P02)

This participant, who was not at all impressed by the imposition IAPT in the early days of implementation, appreciated the introduction to patient management systems, taking to its use easily, whilst valuing the space it freed up for therapeutic contemplation,

I liked the tidiness of it … to be able to … see where I was at … regarding writing up and … appointments … I liked that ... I liked … that that took care of that side of things, leaving me to being able to think of the therapy for the person (P15)

The results from data collection were also reportedly used as a performance management tool. This was perceived as unfair, unethical, and punitive towards counsellors, in turn, challenging professional self-esteem and development. The next participant, who had experienced this in numerous IAPT services, felt a sense of continual scrutiny and

judgement, based on client outcome, as opposed to therapist skill and commitment. It was almost ‘as if’ the measures were designed to assess the therapist,

> *I did feel like, ‘I’ was being measured - like a patient should fit these measures, and so should the counsellor (P03)*

This sense of continual intrusive watchfulness, was perceived as being intimidating to participants. The next participant, shared that this had extended to the analysis of therapist outcomes. This service prepared individual spreadsheets for therapists, detailing performance and outcome figures. The participant found this process aggressive, to the point of affecting professional development,

> *Every three months, we were given a spreadsheet to tell us how effective our form of therapy has actually been and how many clients we’ve seen … I felt quite scrutinised, I wasn’t able to sort of develop professionally (P06)*

The confusing manner in which IAPT data is collected and used can have implications for professional development. If used clinically, as a client treatment tool, it has been largely supported by participants. Participants, perceived this use (from a clinical perspective) as a positive developmental tool, enhancing therapist and client knowledge, whilst benefitting therapeutic delivery. Some participants were very much opposed to its use on ideological grounds. When used as a therapist performance management tool, it can cause distress, and could be perceived as an impediment to professional development.

4.3.15 Code: Manualised

Participants expressed thoughts, feelings or references to IAPT manualised therapies. Such therapies are distinct from idiographic and nomothetic therapies per se, as they have been developed explicitly for clinical use in IAPT. Examples would be ECfD, DiT, IPT, CBT, CCfD, and PWP training. It is interesting to note the participants views and experiences of IAPT manualised approaches and to consider its influence on professional development.

The manualised approach was not always perceived as being negative. This participant, having sought permanent employment in a number of IAPT services as a counsellor or high intensity therapist, opted to take IAPT PWP training to expand knowledge, and secure a permanent contract of employment,

> *The PWP course gave me other aspects and other angles to different conditions in the way that I work, and I think it has helped the way that I have worked (P03)*

The next participant, was employed in IAPT on a permanent contract from the outset. This participant had trained to certificate level in CBT (pre-IAPT). After IAPT implementation, the participant felt pressured to train in IPT, a professional development choice that would not have been chosen without IAPT clinical and business pressure. The participant takes a reflective stance; equally recognising value in the manualised approaches, but also lamenting the imposition of IPT,

> *It's not that I would ever say that any of these [IAPT] therapies are bad or wrong obviously, but ... I consider that I'm a pretty good therapist, I get good results, I didn't need to do that [undertake IPT training] (P04)*

The methods employed, in manualised training and delivery, were an impediment for this participant, who expanded on the earlier comments. It is interesting to see how the manualised approach can clash with a counsellor's values and therapeutic autonomy,

> *I don't hate IPT, I think it's a really good model, but I have never really used it since … I don't really see the need ... it was so awful to have to ... work in that rigid way. I just felt like a robot some of the time (P04)*

This lack of autonomy was reflected in other participants comments. This participant held a degree in, and was an experienced psycho-dynamic therapist. The comments seem to reflect a sense of IAPT approaches being formulaic, lacking in originality, and clinically restrictive. This participant shared a frustration with this approach,

> *It felt almost as if it was almost like a tick box exercise rather than actually working professionally to the best ... for our clients (P06)*

It is worth noting that IAPT approaches, being manualised to IAPT clinical and business needs, are not truly reflective of the original modalities. The following participant qualified in counselling to master's degree level, and also in the IAPT ECfD, recognised this difference. It was enough to persuade the participant to decline the opportunity to train in the IAPT version of CBT,

> *I've done some CBT, but … I wasn't really interested in the IAPT CBT (P10)*

Participants' ambivalence to the manualised approaches, with its clinical constrictions, may help to explain why some services appear to deny counsellors opportunity to train in the IAPT approaches. When this participant, who struggled with the formulaic qualities of IAPT approaches, sought IAPT training in CBT, the counselling background and experience was cited as being inconducive to IAPT CBT approach,

> *I was told that my modality, my background wasn't conducive to then going on to CBT training (P06)*

The IAPT manualised approach to therapy, in clinical terms, can demonstrate its efficacy over more than a decade of outcome measurement. What is important to recognise here is that participants (and perhaps counsellors generally) can struggle to adapt to the lack of clinical autonomy and therapeutic constrictions that it represents. It is, after all, situated in a nomothetic generalised ideology, whereas counsellors are differentiated by their idiographic non-generalised stance.

4.3.16 Code: Supervision

Supervision is defined by BACP under the Ethical Framework for the Counselling Professions 2018 point 60,

> *Supervision is essential to how practitioners sustain good practice throughout their working life. Supervision provides practitioners with regular and ongoing opportunities to reflect in depth about all aspects of their practice in order to work as effectively, safely and ethically as possible. Supervision also sustains the personal resourcefulness required to undertake the work*

[https://www.bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions/]

Given the importance of supervision in counselling, the references from participants to that relationship were scare. References were made to the value of both formal, and informal peer supervision. It was interesting how participants (as counsellors) recognised need amongst others, often seeking to provide support and peer supervision. The following participant, not trained in supervision at that time, relates being drawn into (in counselling terms) a peer supervisory role,

> *I also found ... in the mornings, when I was going in to do my notes ... young colleagues coming in and needing a chat ... because they were dealing with 80 to 100 cases – that was their case load – a rolling caseload which was obviously far too much (P02)*

The supervision experienced by one participant appeared to be highly valued in terms of managing the level of work demanded in IAPT. This suggests that therapists could feel a lack of peer, managerial, or clinical support in therapeutic delivery,

> *I've [had] an excellent supervisor ... she's really good, but I felt, other than that, there is no support to work at that level with people (P10)*

Participants shared aspects of IAPT supervisory provision, which might differ from the processes commonly experienced in counselling supervision. A strong element of tutelage

was apparent, educating and guiding therapists in the use of diverse approaches through supervision. This was not received negatively by participants. In the two following extracts, both participants were employed on non-permanent contracts. They were both unable to access formal IAPT training, and both supervisors (unconnected to each other in any identifiable way) had provided ad-hoc training in the first extract in CBT, and in the second extract, Solution Focussed Therapy,

> *I had supervision ... with a cognitive behavioural therapist within IAPT, and during that time ... she was giving me lots of literature to read, obviously supervising my practice and ... I was actually using these techniques within my practice (P02)*

> *I've not sought out any solution-focused training, but, by virtue of ... going to meetings ... supervision groups, or supervision sessions, you've ... got to know the way other people are working and ... pick that up by osmosis (P09)*

The difference between IAPT supervision, and that which counsellors expect in a supervisory relationship was also apparent. During the training phase of IPT, the supervisory provision experienced by one participant appears to have been divided between two supervisors, lacking cohesion, modal integrity, and support,

> *There was lots of flaws in the way the support was ... at different points I had two different ... IPT therapists who were supervising me, but the problem was ... they'd done the proper IPT training that wasn't reduced, so they were supervising me to do something they haven't done themselves, and it caused terrible trouble, it was really stressful (P04)*

The difference in supervisory expectations between counsellors and that which IAPT provided, was stark, when viewed from the experience of the following participant. This participant (a senior practitioner) was providing supervision in an NHS PCMH service, when IAPT was implemented. The participant was astonished to have the established supervisory practices removed, and to be returned to a full-time therapeutic role,

> *We were taken over [by IAPT] and right away our … supervision [model] was taken off us and we were just doing therapy (P15)*

The experience of working in IAPT contributed to some counsellors becoming supervisors, outside of IAPT. This first participant attributes experience of working in IAPT with the progression from lacking in professional confidence to being employed as a supervisor in a non-IAPT role within the NHS,

> *I think [as a result of working in IAPT] from having quite low self-esteem; and can I really do this job? I went on to become a supervisor of other therapists (P02)*

This participant, having training in ECfD and then the supervision of counsellors using ECfD, attributes this development with (post-IAPT) working as a qualified supervisor of counsellors,

> *The IAPT training, the ECfD … it's enabled me to do more formalised supervision … so, I'm a qualified supervisor now, which I didn't have before (P10)*

The provision of supervision in IAPT appeared to differ from that which counsellors expected, or had previously experienced. In IAPT services, it would appear that supervision can take on a teaching or coaching role - tutorial rather than exploratory in nature. Counsellors may experience this as being supportive to their professional development, or lacking in the reflective element, prized by many, to maintain and develop their personal as well as professional resources.

4.3.17 Code: Treatment

Knowledge and skills, which participants had been introduced to and developed in IAPT, were often integrated into their individual treatment approach. Despite counselling being recommended for depression only, participants were exposed to a broad range of presenting problems that required treatment. The following example, gives an insight into the exposure of counsellors to severe presentations, that can register intense and frequent levels of therapeutic need,

> *I had people who were having active suicidal thoughts, people who were actively self-harming where GPs had given them means at home to dress their wounds, you know, that kind of thing. So, these were quite tricky clients to work with (P02)*

The demands of these challenges seemed to encourage participants to expand their professional worldview, clinical knowledge, and application of approaches in order to meet the needs of their clients. Summed up by one participant, who had been strongly critical of IAPT, the general view was that despite their differences, participants could see overall value in integrating aspects of IAPT's treatment approaches. The implicit argument for pluralism is notable,

At the beginning ... because my main training was person centred, that was what I was doing with the clients ... but then as time went on ... I did additional trainings and … you integrate aspects of those, and then you just become a better practitioner (P04)

The value of a broader (more pluralistic) stance was transferrable outside of IAPT. Other participants reflected this position, such as the following participant – originally psycho-dynamic – subsequently, adopting a broader treatment model,

From my own development … I think it was really useful because now I'm in private practice, I can still use some of those [interventions] for different clients (P06)

Another participant, voiced appreciation of the experience gained in IAPT, attributing IAPT service with the development of a personal model of therapeutic approach,

There were definitely some benefits to working in IAPT, because ... it gave a good, broad spectrum of people and problems ... I learned a lot from that ... it shaped how I worked (P09)

IAPT can offer a broad range of clinical experience for counsellors, seemingly elevating their knowledge, skills, and confidence. In terms of professional development, from a treatment perspective, IAPT appears to challenge counsellors to adapt to the needs of their clients, and the needs of their clients are diverse in nature, and severity. There was unilateral

agreement that this was beneficial professional development. Overall, participants shared a humbling level of commitment to professional development in the face of treatment requirements, that may not have been envisaged in their original training. There were indications of strong professional development, ironically in some cases, without formal support or input from IAPT, which was subsequently (in all participant cases) lost to IAPT, and more importantly to its service users.

4.3.18 Summary

This section of the findings chapter has sought to set out how the clinical model of IAPT might affect counsellor's professional development.

4.4 Theme 3. The Counsellors Response to IAPT – How it Affects Counsellor Professional Development.

This section of the chapter contains the data from the interviews that suggests how the participants responded to, or engaged with opportunities for professional development in IAPT service. How facilitative, if at all, the professional development of counsellors was, and how those participants conceptualised and responded to the professional development opportunities available from IAPT. There can be no doubt that each participant struggled with aspects of IAPT, relative to their professional development. It is also worth noting that some participants were able to adapt to the IAPT environment and leverage opportunities to develop professionally. Having a clear understanding of IAPT, how it can contribute to, and how it can impede counsellor's professional development is important to making empowered decisions around professional development.

In the appendix are three tables that provide a summary of the prevalence of codes identified in each theme of the study: Theme 1, The Business of IAPT; Theme 2, The Clinical of IAPT; Theme 3, The Counsellors responses to IAPT. It is hoped that this will help the reader to identify how frequent the issues were observed across the research population.

4.4.1 Code: Agency-Active

Agency is the capacity of an actor to act in a given environment. In this study, an agent can be described as a counsellor engaging with the business, clinical, and social structure of the IAPT programme. The level of reflexivity a counsellor may possess, and communicate may be relevant, as decisions to engage (and therefore take agency) may rely upon the counsellor valuing his/her professional development, recognising and making decisions on what IAPT has to offer. This section of the findings explores agency in the participants relating to both Active and Passive agency regarding their professional development.

It was interesting to note why participants had actively chosen to work in IAPT. One clear professional development motivation was the facilitation of clinical placements in original training. The irony of IAPT facilitating counselling training posts, an approach that IAPT does not support, should not be lost on the reader. The following extracts demonstrate two different motivations for actively entering IAPT. The first, after having worked in a traditionally counselling environment, seeking to then extend knowledge into a more medicalised placement,

> *I found a clinical placement within a local hospice, and then I decided I wanted a bit more. So, I contacted the local IAPT service … and asked if I could come along and do some clinical placement there for six months … they said yes (P02)*

The second, being aware of the medicalised aspect of IAPT, was reluctant to experience early development in such an environment, but feeling compelled to engage with the development on offer,

> *I was a bit resistant to going into IAPT … a bit reluctant to go into the NHS, cause I didn't think I wanted to ... have that medical model. But equally, I needed a placement (P09)*

Other participants, were qualified counsellors in PCMH service prior to IAPT. These participants demonstrated active agency through engagement with opportunity. Knowing how systems work and having relations to leverage may have helped. The first extract, represents a participant who chose to add to original training, integrating the knowledge with original training to good effect,

> *My main training was person-centred ... but then as time went on ... I did additional trainings and obviously when you do that, you integrate aspects of those, and then you just become a better practitioner (P04)*

The next extract, represents another person-centred counsellor who actively petitioned management to provide the IAPT ECfD training be made available to counsellors. This led to the participant becoming a trainer in ECfD,

> *I … petitioned that we could do the ECfD training and that was supported, and we managed to do that (P16)*

Another aspect of active agency, is the decision to ‘not’ engage with opportunity. In this study participants shared examples of choosing against engagement with IAPT professional development opportunity. In the following extract, the participant was a highly qualified counselling psychologist. When offered an opportunity, to train in low intensity cognitive behavioural, guided self-help approaches the participant turned it down. The participant saw such an opportunity as regressive rather than developmental,

> *At one point I was offered … PWP training ... I saw that as a retrograde step (P02)*

The second extract, from another person-centred participant with extensive experience in PCMH, chose to decline ECfD training. This participant, recognised the interesting methods that IAPT was developing, but chose to maintain the orthodox person-centred approach that had served well through years of service,

> *The counselling for depression … model did come through … it was obviously another interesting approach … I chose not to (train in ECfD), so, I wouldn't say I couldn't have done it (P15)*

Whether, within or outside of IAPT service, participants demonstrated agency in their commitment to professional development. In the following extracts, the participants sought out and engaged in privately funded training that was suited to their own approach and ideology. The first extract is from a participant who sought solution focussed training, which was accepted by the IAPT service offering employment,

I undertook a course in … [Solution Focussed Therapy] in university. ... I really do introduce it in part of my work. It marries well with person-centred counselling (P03)

The following extract, was from a participant post-IAPT, who revelled in the freedom to explore and develop, without judgement or impediment from an IAPT employment perspective. Outside IAPT participants found it easier to exercise active agency in professional development choices,

I've been on a course about attachment ... and I'm going on a … course ... about working with adult survivors ... I'm thinking about doing a ... Gestalt workshop next week ... and I've got all these books I've bought ... I'm reading ... about compassion focused therapy (P10)

Participants had left IAPT for varied reasons. In the first extract, the participant was faced with a realisation that permanent paid employment was not forthcoming. Demonstrating active agency, this participant left IAPT and set out to build a private practice. This was a bold choice, fearful of not attracting clients, the participant made a strong commitment to professional development that paid off and served well,

I really had to start focusing on my private practice … so, I found a room to rent, an office in an osteopath clinic, and I've been doing that for the last six years (P02)

The following extract, reflects the sense of freedom to practice that this participant was denied in IAPT service. Making the choice to exercise active agency, leaving the NHS to

build a private practice, had been so emotionally threatening to this participant, that relating it (in this interview) years later invoked tears of relief,

> *Now I've got the complete freedom to do whatever I want because I work for myself … it's like anything, you should take the bits that work, that the client needs, and use them (P04)*

Exercising active agency in professional development has proven to be difficult in IAPT service. Participants have shared experiences of exercising active agency in professional development, each experienced a degree of positive outcome when instigated by themselves and/or facilitated by IAPT.

4.4.2 Code: Agency- Passive

Passive agency, is essentially the acceptance of circumstances, not exercising agency and allowing situations and opportunities to take their course. With regards to professional development, in institutions such as the NHS, there is an understandable presumption that professional development will be formalised and delivered to all employees. This study has discovered that formal provision of professional development cannot be relied upon in IAPT. The following extracts, highlight a sense of passivity in the participants, through the shared use of the term 'ended up',

> *I ended up in the IAPT setting because ... they were looking to bring in some counsellors to reduce the waiting list times ... and offered me the opportunity to come in and work with them on a [fixed term] contract basis (P03)*

The reason I ended up in an IAPT service was because I moved … and it was the only agency who was taking on qualified counsellors (P06)

Participants working in IAPT may not have considered the Professional Development opportunities available. It was noted that participants did not express a professional development strategy regarding their career. This was taken to be a generally passive stance, that may or may not be reflective of a greater attitude to professional development in counselling. In the following extracts, the participants express an implicit lack of purpose beyond working as a counsellor. The first participant, whose attitude towards professional development changed through IAPT service, entered IAPT with no recognition of the value of a structured professional development strategy, almost suggesting that that the qualifications and experience held were the end result,

I didn't really analyse how [professional development] ... would work for me ... I just assumed that I would be coming in, working as a counsellor (P03)

The second extract, suggests that the participant started working in IAPT because there was no other identified opportunity, and that no thought of professional development had been considered,

I don't think I was on a path ... I suppose I didn't really ... know where else to go really (P10)

Passive agency, as regards professional development, was evident amongst participants when employed in IAPT and attributable to varied pretexts. In the following extracts participants share their lack of structured planning, perhaps encouraging reliance on IAPT provision. The first participant, reflects upon the lack of professional development strategy because of a belief that IAPT would take responsibility in that regard,

> *I didn't have a structured plan, but didn't really need one at that point, because I was in an organisation that had promised to support my development (P04)*

The second participant, reflected upon the comfortable feeling that regular income, and IAPT directives encouraged in terms of compliance. This participant was aware of the stagnation of ambition that could result from being compliant,

> *The longer I was in there the more I got sucked into the ... regular income ... I was doing things to stay, and … to comply with the IAPT ... it wasn't always a comfortable feeling (P09)*

Passive agency can result in positive professional development outcomes. Participants had shared that compliance had resulted in positive learning and development. However, it was also recognised that IAPT management could use sinister motivations to encourage engage or compliance. The final participant extract is reflective of a number of comments from participants regarding the threat of losing employment, if they did not comply,

We'd been threatened we'll lose our jobs if we didn't do [CBT training] ... I did it, and I learned a lot (P04)

The lack of a professional development strategy can make counsellors vulnerable to manipulation in IAPT - arguably, in other employment settings also. It would seem obvious that a counsellor with a professional development strategy, would be more able to consider how opportunity could contribute to development. This would facilitate purpose, and commitment to training when accepted. Passive agency, seems to be more likely when counsellors lack such purpose, and expectation around outcome is less predictable.

4.4.3 Self-Belief

During counsellor training there is a considerable element of time and resource devoted to personal growth and the development of a strong capacity for internal evaluation. Counsellors – as a result – learn to rely on this aspect of self-management in relation to their work (and also private lives) as a guide to maintaining elements of the Rogerian core conditions of Respect, Congruence, and Empathy. In theory, internal evaluation is challenged by the concept of external evaluators (a classic example would be generalised knowledge). In order to achieve those Rogerian core conditions, in practice and personal relationships, a balance needs to be found, and maintained, in what is a dynamic commitment to self – the self being a core aspect of the counselling process within a therapeutic relationship. In IAPT the strong, and often overpowering, external evaluators created by measures, such as: manualised approaches; NICE guidelines; contractual demands; programme related procedures and policy, can and will have an affect counsellor's self-belief. This section of the findings explores the coded narrative, relating to self-belief (negative, positive and uncertain) in the participants and how working in IAPT may

have influenced (whether positively or negatively) that self-belief with regards to professional development.

4.4.4 Code: Belief-Self-Negative

Participants shared their thoughts of how the IAPT experience could contribute to a sense of negative self-belief, affecting both the professional and person aspects of their selves. Organisational messages, both explicit and implicit, contributed to these outcomes. In the first example, the participant shared how clinical messages influenced doubt. It was interesting to reflect upon the participants owning of the negativity; that it was not just the counselling approach, it was also the participant that was not 'good enough',

> *You know that it worked [Counselling] but then you're getting told that it doesn't work, you're not good enough, you're not a CBT therapist, we don't value, you (P04)*

To a degree, this might be reflected in the following extract. This participant argues that, despite getting good results and being respected as a person by colleagues, paid work was not offered. It is arguable, the degree to which there is a conflation of model and self,

> *I couldn't get paid work ... working with step three patients – who can be really quite poorly – and … I did have pretty good results. I was very well respected amongst my colleagues, and they couldn't believe that I wasn't paid (P02)*

The next extract also highlights a sense of personal rejection, linked to modality and training. This participant placed themselves in a kind of virtuous hierarchy, and whilst there is no

element of what peers thought of the participant, as in the previous two extracts, the training referred to was non-IAPT training,

> *It felt as if I was on the bottom [of the hierarchy] even though I'd gone through all my training (P06)*

Perhaps adding to the confusion and conflation of professional and personal self, the participants also remarked on the effect of modular criticism. Suggesting that the participants could be confused and conflated around self-belief. The first participant, qualified in CBT, expressed a stoic understanding of the effect of IAPT business and clinical influences on counsellors,

> *My experience was ... there's CBT. If there was a hierarchy of what … seemed to impress the business model and the medical model … CBT fits very well (P03)*

There was also a sense of disparity, of unfairness attributed to the system of measuring outcome. The following participant, expressed despair at the way that outcome measures were used to define value related to therapist and method,

> *It wasn't just the measuring; it was also the way that it privileged other types of therapist and their approach (P04)*

The effect of organisational values, expressed towards outcome and modality, was clearly conflated with personal value in the participants. In all of the participants, there was a shared

sense of counselling being undervalued. In the following extract the participant expresses a worrying outcome of being exposed to such pressures. This participant questioned their own career choice. It could have a very damaging effect on professional development if the counsellor chose to leave psychological therapies. Thankfully, this participant did not leave the profession,

> *I've obviously taken some tools away with me … but it really affected my confidence as a therapist – and it made me assess whether I wanted to continue within the profession (P06)*

4.4.5 Code: Belief-Self-Positive

Whilst participants expressed negative impact on their self-belief, it was also interesting to note that IAPT could boost their self-belief. The key element appeared to be centred around the development of a broader spectrum of clinical knowledge, skills and experience. The following extract is from a participant who had struggled with negative attitudes and values towards counselling, and yet, this participant had developed a more pluralistic or integrative approach. It is difficult to tease out the reason for this effect, though it could be argued that in challenging circumstances, the participant sought and discovered ways to meet client need and be valued by IAPT. The outcome seems to be greater self-belief,

> *It was useful [IAPT experience], because what some of that has given me is a formal integrative model which is very helpful, so you know, obviously, more tools you got, the better (P04)*

The following extract, reflects a similar appreciation of professional self-belief. This participant, having completed a master's degree in counselling, despite having shared earlier reservations about working in a medical model, discovered the experience of working in IAPT had contributed to greater self-belief,

> *There were definitely some benefits to working in IAPT ... it gave a good, broad spectrum of people and problems ... I learned a lot from that ... it shaped how I worked (P09)*

Participants shared their confidence at being able to responding to changing demands. The following participant spoke confidently about being able to meet client and clinical needs by adapting therapeutic stance,

> *Therapies that I've been introduced to, allow me to adapt me sessions to work with certain issues quicker (P03)*

Similarly, this participant had developed an assured manner in which to respond to changes in treatment time scales,

> *I was allowed to work whichever way I wanted to, but on a brief sort of model ... initially, it was up to six sessions ... but then, after a while, it was reduced to between four and six sessions (P06)*

Those participants who had experienced IAPT training had a sense of boosted professional self. The following participant had embraced PWP training, speaking highly of its professional development benefits,

> *It [PWP training] give me insight into working in a way where you'd work differently with assessments ... different conditions that exist, especially with anxiety ... a more medicalised viewpoint of working with people … grouping symptoms and how symptoms can … overlap ... It wasn't a bad course. It was quite good (P03)*

The ECfD training was well received by those participants who had engaged. This participant, who had previously taught person-centred counselling, referenced feeling refreshed by the training, feeling validation for the person-centred approach within IAPT,

> *[ECfD training] Got me back in touch with when I did my [Person-centred] diploma … it made me ... think, Wow! This approach is so powerful, and it really has people change at a really quite deep level (P10)*

It is becoming clear that working in IAPT effects counsellor's self-belief. It can have both positive and negative effects.

4.4.6 Code: Belief-Self-Unsure

On the continuum of positive and negative effect on self-belief, there were also elements of participants feeling unsure and destabilised. It was disturbing, to observe how the IAPT working environment can have participants become unsure of themselves. The following

participant, shared the moment when colleague feedback led to a realisation, that the participant could choose to leave the NHS. The lead up to this had been an ideological struggle within the participant. The dominance of IAPT business and clinical ideology had affected the participant deeply. The participants resistance to this, along with efforts to find ideological and clinical compromise was costly. It resulted in a tipping point, struggle on or seek pastures new. Whilst, sharing this moment the participant was reduced to tears,

> *One of my friends said something to me one day which really shocked me … she just said to me, 'You've done your time in the NHS' – I'm crying now – she said you've done your time in the NHS [crying], because I'd been there like 11 years – I'd done 11! You don't realise do you ... how long you've done something for ... and I was like wow! ... I devoted most of my working life up to that point to this, and she's like, you don't need to do it anymore [crying] (P04)*

In understanding and contextualising the above extract, it is worth considering that the fusion of a counsellor's ideological and clinical approach is profound; often not understood by those who have not trained in, or have lived experience of idiographic approaches. It is an aspect of therapeutic practice that is not recognised or developed in the IAPT approaches. The next extract exemplifies counsellor use of self. On reading the extract, some might consider that this participant was unsteady or vulnerable - on the contrary - this was a counsellor who had over 30 years' experience of practising nursing and therapy, who presented as robust, grounded, and reflexive. It was interesting to observe how IAPT could challenge this participants self-belief,

In order to work really well with people, I have … to feel quite centred myself ... feel like the environment I'm in has to be pretty steady ... I feel as though I have to feel … okay with myself and, feel … secure, and [in IAPT] I didn't feel secure (P10)

In many working environments, people can experience a lack of self-belief. In psychological therapies, a practitioner (of both idiographic and nomothetic ideology) can only benefit from a stable, nurturing working environment. In this study participants experienced a lack of stability and nurture.

4.4.8 Change

IAPT changed PCMH. The participants of this study represented counsellors who had been employed in PCMH pre-IAPT, and counsellors who had joined post-IAPT. With regards to both categories, change was required in order to function in a model that was ideologically diverse. In order to identify and understand aspects of participant response to the professional development challenges of IAPT, this study has adopted and interpreted the work of Norcross, Krebs, and Prochaska (2011) to frame participant responses to change. The five stages of change are framed as: Pre-Contemplative; Contemplative; Preparation; Action; and Maintenance. This section explores how that change – experienced through working in IAPT – may have influenced professional development.

4.4.9 Code: Change-Pre-Contemplative

Pre-contemplation is the stage in which there is no intention to change behaviour in the near future. Most participants in this stage are unaware or under-aware of their problems. Others around them, are often aware that the pre-contemplators are challenged. Regarding IAPT, participants were, initially, unaware of the strictly medicalised stance of the IAPT programme

and how it would affect their work. Participants expressed a belief that their qualifications – post-counselling training – were sufficient to support employment, therefore there was no need to change. This participant, having qualified in an MSc Counseling Psychology, assumed that employment was guaranteed, and had not considered a professional development strategy,

> *Nobody really focuses on life after training, do they? We kind of assume … we are going to get work (P02)*

The apparent lack of professional development planning, was mirrored in the following participants comments. That work experience would provide all that was required,

> *My career plan would've been to move to more general [counselling] work, and luckily that just happened … just to develop as a counsellor (P04)*

Participants, seemed to lack a considered vision of the broad range of environments and specialisms in which counsellors could be employed, and where they envisaged themselves,

> *I didn't necessarily know what counsellor I was (when I joined IAPT) but, I suppose, I sort of had an idea (P09)*

Participants appeared to be unaware, or naïve, with regards to the changes that IAPT would demand of them; how that might affect personal development plans, or approach to therapy.

This participant was experienced in PCMH, with decades of experience, and yet the need to consider change (post-IAPT) was unacknowledged – classically pre-contemplative,

> *Whatever we used, whatever approach ... didn't matter as much as the relationship really – the relationship with the client (P15)*

Participants had shared no real vision or understanding of the need to change or adapt approach when engaging with IAPT. It is interesting to consider, whether this is a general reflection of counsellor's attitudes to therapeutic approach; that counselling is a panacea for all psychological distress. That counsellors will be welcomed and employed in all clinical settings.

4.4.10 Code: Change-Contemplative

Contemplation is the stage when people become aware that a problem exists and are seriously thinking about addressing the problem, but yet to commit to change. In this stage the person will struggle with knowing how much the cost of change will be, and whether it is worth the effort. The next participant, towards the final years of a long PCMH career, contemplated change, adapted a little but avoided a commitment to change,

> *I wasn't frightened of being sacked ... I didn't really do anything wrong, but I didn't change greatly how I worked (P10)*

Other participants, who sought permanent contracts in IAPT, considered and made a commitment to change,

I was a humanistic therapist and I decided that I needed to learn a bit more about things like solution focused therapy, cognitive behavioural therapy (P02)

I remember reading up on solution-focused counselling. I quite like that model because it ... gave alternatives to ... working with core conditions ... offering people more practical ways, sometimes, of solving … issues which arise in everyday life (P03)

The contemplation of change with regards to participants came post-IAPT implementation. It would be a fair reflection to state that none of the participants envisaged a need for change. However, counsellors share reflective qualities, and the outcome of contemplating change was an openness to, if not a commitment to change.

4.4.11 Code: Change-Preparation

Preparation is the stage in which people are intending to act or are experimenting with small changes prior to committing to change. There was little evidence of participants preparation regarding clinical or ideological change, those comments made were post-change related. In relation to leaving IAPT, some participants shared their thinking and behaviour prior to leaving IAPT. The following extract, highlights the participants experimenting with private practice as a preparation for change, after realising that the promise of permanent employment was not happening, and that clients would be attracted to the participants practice, the participant was preparing to act,

So, the writing was on the wall. I'd been … working five-day week then doing private practice on Saturday morning, just to see if it was possible, and I thought, actually, I'm getting clients here – I can do this (P02)

The paucity of evidence, in terms of participants preparation does not necessarily equate to participants being spontaneous in relation to change. Having met with and interviewed the participants, I was left feeling that these people were thoughtful and responsible professionals. In the narratives many had shared their thoughts on change, such as applying for a PWP course, or petitioning for ECfD training; these examples were less preparatory and more action based.

4.4.12 Code: Change-Action

Action is the stage in which individuals make a commitment to change, which can require a considerable commitment of time and energy. Participants shared their experiences of being engaged with change. In this extract, the participant having engaged with ECfD training, implies (trying to stick to it) an ongoing need for commitment to changes in therapeutic approach,

I did try and stick to it ... the CfD model, because … when I did the training … I really enjoyed it (P10)

Whilst IAPT required change for counsellors, the participants who responded to those opportunities experienced the challenges of adapting, learning new ways, and consolidating those changes.

4.4.13 Code: Change-Maintenance

Maintenance is the stage in which people work to consolidate the gains attained during action, consistently engaging in a new approach. Participants shared the benefits of change experienced in IAPT, particularly those practices learned in IAPT that are transferable outside of the NHS. In the first extract the participant owns the maintenance of that change experience, recognising that having seen other ways of working it is not possible to delete that knowledge, and yet it has been integrated into the person-centred model or original training,

> *You can't un-know things, can you? I've just learned a way of doing things without losing my … person-centred values (P02)*

The formality or structure of IAPT had an effect on a number of participants. This participant, now working a successful private practice, highlighted the developmental benefits and value of a formal integrative model,

> *It was useful, because what some of that has given me is a formal integrative model, which is very helpful, so you know, obviously, more tools you got, the better (P04)*

Another participant, again working privately and also in an NHS (non-IAPT) clinical supervision role, shared how IAPT had modelled a benchmark of practice standards and professional development insight,

I used a lot of their stuff as a kind of a benchmark for... my own practice, and my continued professional development (P02)

IAPT had activated change in participants. The type and value of change, and the way in which individuals responded to those changes differed. What was notable, was the commitment by participants to maintain and build on those changes.

4.4.14 Engagement

Participants experiences of working in IAPT (and its consequent effect on professional development) differed in relation to many aspects of the working environment. This section of the findings explores the experiences of participants being or feeling that they were professionally engaged (and thereby accepted) as part of the IAPT programme. It has been sub-coded into engaged (acceptance) and disengaged (rejection).

4.4.15 Code: Engaged-Acceptance

The following participants shared experiences that suggested a difference between IAPT nationally, and the way in which IAPT was interpreted locally. The following participant, was able to engage with local, service based, training. It was conceptualised as helpful,

[the service] would offer sort of courses on working with depression and anxiety and looking at how different conditions are measured, the different symptoms … it was quite helpful (P03)

As had been highlighted in an earlier section, one participant had petitioned locally, for a national training course in ECfD. This had been successful and improved engagement for the participant at that time,

> *I … petitioned that we could do the ECfD training and that was supported, and we managed to do that (P16)*

The introduction of ECfD by IAPT was a clear acceptance, and validation of counselling and counsellors in IAPT. The following participant had many years of person-centred experience and practice. Notwithstanding this background, the participant engaged with the training, was almost rejuvenated from the manner in which the model was presented,

> *I realised how powerful it is as an approach [ECfD] and if you really stick to it, and you really do work in that way, and you don't sort of veer off to get other things involved – it's really, really powerful (P10)*

The promise of counsellor appropriate professional development had a positive effect on participant engagement. The following participant shared a change of perception and energy, when news filtered down of a counsellor specific approach,

> *When I discovered about the fact that we were getting an approach that was based on person-centred theory, I then started to get more interested (P16)*

In terms of professional development, there was evidence that participants in this study were able to engage with IAPT training. It was interesting that participants were more likely to engage with counsellor appropriate training.

4.4.16 Code: Disengaged-Rejection

The following section of the findings, explores the participants experiences of feeling professionally disengaged, rejected, excluded from, or not being a part of the IAPT program. Despite the introduction of ECfD, participants experienced a sense that counselling was less valued than other modalities. This was conceptualised as a rejection of counselling. The following participant was still (some years later) animated when sharing an early experience of IAPT. The service had begun a restructure, which included changing the pay band that counsellors enjoyed. The participant expressed great frustration at the service choice to lower the counsellor's wages. It was conceptualised as a statement of the value that IAPT had placed on counselling, resulting in a sense of disenfranchisement,

> *They tried to down grade us. I mean, you can't get any worse than that in terms of you're not valued can you (P04)*

Feeling disengaged was also an outcome of observing the privilege extended to CBT therapists, particularly with regards to salary. Counsellors in this participants experience were paid (and valued) less than their high intensity colleagues who practiced CBT,

> *The CBT therapists ... they had the privilege automatically ... they were paid ... on a band seven, we're on a band six, which I felt was unfair (P10)*

If being valued below colleagues, who worked at the same intensity as themselves, was not enough to dis-engage participants, there were numerous examples of counsellors being coerced into IAPT training that they did not seek. This next extract, is a clear example of the lack of effort to participate with and encourage participants to engage with IAPT. The participant felt that counselling was unwelcome that they would lose their job if they did not comply with IAPT training,

> *They threatened me with not having a job if I didn't do IPT (P04)*

The following participant, experienced a similar sense of coercion,

> *They [local management] said that I would have a reduction in my hours and my income if I didn't attend the [CBT] training; I couldn't afford to do that, so I attended the training (P16)*

This study has indicated that IAPT, as a national program, has the potential to engage with the counsellors that work in PCMH. The training that has been developed and offered in ECfD, DIT, and to a degree IPT could be leveraged nationally with a greater commitment towards engaging and developing the counsellor. It seems that the focus and bias towards CBT remains. Participants in this study had shown clear inclination to engage with professional development opportunity, it is a shame that this interest does not appear to be reciprocal.

4.4.17 Frustration

Brown (1954) Describes the concept and negative consequences of frustration in detail, whilst defining the phenomenon as, "When a person is motivated towards a goal and something interferes with his progress towards it, he is said to be frustrated" (p.245). Brown posits that frustration can lead to four types of reaction, behaviours characterised as: *Aggression,* commonly recognisable as excessive criticism of management, malicious gossip, voicing of superficial grievances, militancy, absenteeism, and neurosis. In IAPT terms, the participants of this study and the literature, report only non-physical aggression; mostly projected towards persons, and objects such as IAPT itself in the form of opinion in verbal and written form (see BACP TT and Rizq etc); *Fixation*, an inability to accept change. Blind or stubborn refusal to accept new facts. Being compelled to repeat behaviours, which prevents the use of new more effective ones. In IAPT terms, this may be present in a counsellor's refusal, or inability to develop outside of the idiographic ideologies of Rogerian person-centred theory. It may also reflect the ability to retrain in IAPT specific modalities, such as Interpersonal Psychotherapy (IPT), or even IAPT Cognitive Behavioural Therapy (CBT); *Regression*, characterised as being more suggestible, prone to confirmational bias, with a yearning for past conditions i.e. the good old days. In relation to this study, counsellors demonstrate fixed opinions on IAPT, negative comparisons with previous counselling services, a sense of loss, coupled with disempowerment. In some cases, manifesting itself in internalised pain, and with a suggestion of resultant negative effect on health and wellbeing; *Resignation*, which is observable by apathy relating to change, particularly to new systems. This would encompass the population of this study on account of having left IAPT, and sadly in all cases with unmet expectation as a dominating feature. The four types of behaviour outlined by Brown have been coded into the analysis as a means of helping to describe the responses of participants and enlightening the reader. As with previous adoption of theoretical explanation the codes are observational and not intended to be morally judgemental.

4.4.18 Frustration-Aggression

Participants seemed unable to understand the pragmatic pressures of IAPT, appearing to project that frustration onto others i.e. Management, Supervision, Clinical leads. The rawness of participants emotions was evident even after having left (in some cases years later) IAPT. The following participants objected to the imposition of data collection, both perceiving this as an exercise that was unassociated with therapy. It was a shame that the data collection processes had not been presented to participants in a therapeutically facilitative manner. It is arguable that professional development opportunity was lost as a result,

> *At one point, we were ... having to do like three or four measures every session with every client, which is ridiculous ... especially when you got like, very distressed people or people who can't read and write properly or whatever reason (P03)*

> *It wasn't just about putting in data ... there's that much stuff you have to put in ... a brand-new client … at risk, that would be a 12-page risk assessment! (P10)*

The previous participant also shared how data could be used as a management tool, frustrating the participant, whilst also building on the resistance to that data,

> *At the end of the month ... it'd be, not, "how are you?" but "have you done?" "You haven't done this, and you haven't done that". Everybody were that stressed (P10)*

Raising grievances with service management was often experienced as negativity. The following participant had been active in a number of counsellor related issues. This participant felt that these responses to the frustration of IAPT service activity had resulted in victimisation,

> *They [IAPT management] wanted me out, oh yeah, and I know someone who's since being pushed out of there ... but they hated her, and they hated me, because we stood up to them, we constantly stood up to them (P04)*

The frustrations that participants experienced in IAPT service were often left unresolved. This facilitated an aggressive stance towards IAPT that could result in participants being overlooked, stonewalled or just plainly demoralised. It was not possible to identify the effect of frustration on participants professional development. However, the energy expended in seeking resolution of those frustrations would clearly be better utilised in professional development activity.

4.4.19 Frustration-Fixation

Participants, blindly or stubbornly, seemed unable to accept development opportunities, outside of their ideological stance. Refusing to adapt, they seemingly became fixed in their approach. The next participant owned, despite being trained in IAPT ECfD, delivering therapy in the way that suited the therapist and client as opposed to following IAPT approaches,

People [Management] didn't know what went on in the room; and what you did try and do – in the room – is work with where the client is at, and where they wanted to go, and how they wanted to be (P10)

Participants appeared to stubbornly resist change (from their idiographic stance) missing the opportunity to professionally develop through retraining in, and working with IAPT approaches. The following participant proudly shared using their own model of therapy along with elements of IPT, rather than IPT as required by IAPT,

I was very proud because ... they [the clients] still got better, and that wasn't because IPT works as such, because it [IPT] was an impediment, I'm sure elements of it did help these people yes, but mainly ... It was me ... madly trying to manage it all the time like, how do I stop it [IPT] from ruining the therapy (P04)

One participant was very clear about change. This participant, was fixed in their approach and did not seek any IAPT influence,

I didn't want what they were offering. They didn't offer much, but I didn't want to be interfered with. I really wanted to carry on doing what I was doing (P15)

Participants struggled to recognise (or validate) the positive aspects of development that can result from their having accepted the IAPT approach to therapy. It is interesting to note that the following participant used some CBT techniques, whilst lamenting being taken away from original training,

It took me away from the psychodynamic model ... I did start to use some CBT techniques … so, in that respect, it did give me some tools that I could use, but it did take me away from my original training (P06)

When participants had accessed training and development in IAPT it seemed that there was an inability to leave original training behind. Interestingly, this may have contributed to a more pluralistic approach. As was stated earlier by a participant, you cannot unknow what you know.

4.4.20 Frustration-Regression

Participants shared their thoughts on how IAPT had changed PCMH, it was clear that IAPT was not conceptualised as an improvement, either on PCMH service or by comparison with what the changes had offered them from a professional development perspective. In the first extract, the participant shares a belief in counsellors' instinctual determination of recovery in clients, and that this could be accepted as evidence of recovery. Implicit in this statement may be a sense that this quality could be lost to reliance on psychometrics,

Before ... IAPT … it wasn't evidence-based in terms of psychometric scores, there was an evidence ... where I could – you know – there was a feel that there was a recovery from the person (P03)

In the second extract, the participant reflects on counsellors continued growth through experience, perhaps as opposed to formal training and compliance to nomothetic approaches. Implicit in this statement may be a sense that learning through experience and exploration could be lost to didactic methods,

People with mental health difficulties don't fit into neat squares [Reflecting IAPT diagnoses], and that was always valued in the past, and it was understood that the people working in that [counsellors] were also going to have to sit with difficulties that they will bring back to discussion, that they will keep reading papers, that they will keep learning, that there will be ... growth (P15)

The next extract exemplifies the participants who had worked in PCMH prior to IAPT. The sense of losing individualised care and specialism is compelling. However, it could be argued that those specialists could be too narrow, and that others would not be exposed to the development of working with a broad spectrum of presentation,

It was fabulous [pre-IAPT], they would sit there [management] and go right - here's this problem "Oh, who do we have who's good with this problem?" "Oh, give it to them" Wonderful! Really, really, individualised. Not just obviously to the client ... but also to the therapist's skillset – So, the client would get the best therapist for their problem (P04)

It was interesting to note that participants could appreciate and value IAPT as a means of professional development, whilst also harbouring a sense of loss for previous iterations of PCMH. I cannot explain this, other than to consider the general frustration that participants experienced in IAPT is reflected in their divergence.

4.4.21 Frustration-Resignation

Observable by apathy relating to change (particularly to new systems), resignation would encompass the population of this study on account of having left IAPT, and sadly in all cases

with unmet expectation as a dominating feature. The narrative suggests a profound sense of disempowerment. In the following extracts, the participants express resignation related to the way IAPT does business,

> *I also realise that we've got long waiting lists. There's a lot of pressure on IAPT services to bring the waiting list down, because there's competition for funding (P03)*

> *They weren't interested (In the client) I don't feel the IAPT service is about clients at all – not really (P10)*

Similarly, how the participants express resignation related to the way IAPT delivers clinically, and how that affects their development,

> *I was doing things to stay and … to comply with the IAPT ... it wasn't always a comfortable feeling (P09)*

> *If you were going to survive and, and continue to work as a counsellor and be paid wages … it was about fitting into the model (P15)*

This participant was resigned to having to retrain rather than practice as a person-centred counsellor,

> *I was a humanistic therapist and I decided that I needed to learn a bit more about things like … cognitive behavioural therapy (P02)*

Another, was resigned to the belief the IAPT professional development on offer was not inclusive of counsellors,

> *I felt like this is as far as I was going to go. You know ... the term ... glass ceilings, but you could almost say there is a glass ceiling for counselling P03)*

There was a general resignation amongst participants of not feeling a part of IAPT, of not being accepted,

> *They didn't want the counsellors ... it was ... as if they were ... stuck with them and they have to offer clients, as part of the contract, a choice between CBT therapy and the talking therapy (P06)*

> *I had the meeting with the HR person and the deputy executive ... I thought that they would understand … and the HR person said, "you are only a counsellor ... you're not a manager, you're nothing here, your view does not matter" So, I resigned (P16)*

Participants were universally frustrated by the lack of a place for, and the undervaluing of counselling in IAPT. Across the population the participants had all variously made efforts to adapt, some had more success than others, ultimately their frustrations had worn them out and they had accepted or became resigned to the dominance of IAPT. All had left IAPT.

4.4.22 Code: Growth

Counsellors who have worked in IAPT will often recognise aspects of their service as enabling professional growth, for example: gaining a better understanding of severe and enduring mental illness; adapting to work in a short-term approach; developing administrative skills etc. The experience of IAPT service is not always negative, in fact it is almost predominantly mixed in its qualities. Much of the growth reported in this study relates to knowledge and skills that equate to greater employability in the profession of psychological therapy. The code of Post-IAPT was included as a sub-category in this section to recognise the effect on professional development having left IAPT. It was interesting to note that some participants had not connected with the growth that they had made, until reflecting on their experiences during the interviews. One participant, on the edge of awareness, asked for clarification during the interview,

> *Maybe, I need to stand outside myself really, to measure that growth. Can I ask? When you … hear of growth, what do you hear? (P03)*

The interview process had offered another participant the opportunity to reflect on the success of their private practice, increasing the sense of pride felt from navigating the challenges of IAPT,

> *Talking to you has been good because, I feel even more proud that I survived that … now I'm thriving … I've made success in my own micro business, and I'm making a living (P04)*

The evidence of growth resulting from IAPT service, was not restricted to reflection during interviews. The following participants shared previously consider reflection on growth,

> *IAPT enabled me to see a possible way of doing [private practice] … and also gave me the courage, and the wherewithal … to realise that I could do that (P02)*

> *Actually, it gave me enthusiasm towards what I would like to develop in the future – and I would like to develop! (P03)*

> *In some ways, it's elevated me to a level I never imagined, because I didn't ever imagine I'd be [teaching] in a university, and pretty autonomous in doing courses that are essentially experiential – So, without IAPT that wouldn't have happened (P16)*

The above extracts might demonstrate something more than growth, perhaps triumph over adversity, most definitely positivity in the participants outlook and commitment to professional development. What was interesting is the complexity of feelings and thoughts that participants had regarding IAPT, and that within all of the struggles and challenges participants were able to take positives from their experiences.

4.4.23 Code: Reflexivity

Counsellors are expected to be reflexive in personal and professional perspectives. Bolton (2014, p.7) states that 'reflection' is about examining personal attitudes, assumptions, prejudices, and habits, and how congruent our actions are with our values and beliefs.

In this regard counsellors demonstrating reflexive qualities would be considering how IAPT had contributed to, or taken away from, their professional development from an internal evaluative perspective. This section of the findings explores the coded narrative relating to participant reflexivity arising out of IAPT service; in the context of how it effects, informs, and even confuses professional development. A common aspect of participants response to IAPT demands was to seek a compromise between the IAPT methods and their own knowledge, values and beliefs. The extract below offers an insight into this challenge, essentially seeking balance between respecting the nomothetic values of IAPT with the participants idiographic values,

> *I still tried my best when I was going into the room, to balance … what was expected of me from IAPT, but seeing the person who was in the room, and seeing what they needed (P09)*

Another participant reflected on the training and experiences of IAPT. Originally a person-centred counsellor, this participant developed integrative values and practices; congruently owning and accepting this as positive,

> *Because my main training was person centred, that was what I was doing with the clients ... but then as time went on ... I did additional trainings, and obviously when you do that, you integrate aspects of those - and then you just become a better practitioner (P04)*

This next participant, who had broad experience of numerous IAPT posts, demonstrates a struggle with congruence in owning the tension between values and beliefs,

I think it's about [values] clashing with it [IAPT psychometrics] ... giving a true picture of what's really going on for the clients, and also, clashing with the values of allowing someone to move at their pace for change (P03)

The same participant, reflected upon the congruence of their clinical actions with espoused values and theories. It was interesting that this participant, whilst not being comfortable working with the IAPT model, was still able to revert to original training, values and beliefs; not having lost therapeutic ability,

[Working the IAPT way] doesn't sit great. I can still work in the way that I work. I can still think about the relationship and use the core conditions in the same way, which is still good (P03)

This is reflected by another, previously quoted participant, who having left IAPT continued to work harmoniously with the integrative approach developed through IAPT,

In an ideal world, we all do things that fit with us and the needs of our clients as we see them … it's wonderful to be back into that now, make choices that are right, rather than impose choices that someone else says are right (P04)

4.4.24 Code: Leaving

Perhaps the final response that counsellors can have with regards to IAPT service, is to leave. Participants shared varied factors that contributed to their reasons for leaving. They related to professional development, personal circumstances, and organisational

impediments on their ability to remain in IAPT. The next two participants shared the contribution of professional development reasons to their leaving. The first of which, employed on a volunteer contract, was continually promised a future that did not materialise,

> *Nothing was happening. So, it kind of gave me a kick up the backside to go into private practice (P02)*

The second participant, having worked in numerous IAPT services, concluded that counselling was their model of choice. IAPT was undervaluing and restricting professional development in counselling,

> *The factors that influenced me to leave IAPT, is I felt constraint as a counsellor, undervalued as a counsellor … Constrained in the number of sessions ... using the measures just as a sole measurement for improvement ... the amounts of paperwork or admin ... there was so much change ... I couldn't relax really, because I would get used to one system and another system would come in (P03)*

Finally, there were organisational influences that informed participant reasons for leaving. The first extract is a demonstration of reflexivity and congruence,

> *There was one ... training day, that was looking at the service, and that's when I got a bit more of an understanding of IAPT, and I think at that time it made me realise that I wasn't sure that I did fit within the IAPT box (P09)*

The second, similar in terms of a tipping point, was a realisation and acceptance that the incongruence of working in IAPT was no longer tolerable,

> *It was the pressures, to do with admin, data, the way we're expected to ... work ... the structure of the session. People ... in my team ... were so stressed they didn't have time to support each other and that is my turning point (P10)*

The participants responses to IAPT practices were varied and individualised, perhaps because of the idiographic nature of counsellors. What was clear from this study was the frustration that participants experienced when working in IAPT. This frustration centred around the business and clinical model of IAPT. Understanding the IAPT treatment paradigm and how it differs from other approaches (particularly idiographic approaches) may help counsellors to frame their expectations of the contribution IAPT can make to their professional development strategy.

4.4.25 Summary

The findings chapters took the reader through the emergent themes of the business, clinical, and counsellors' responses to IAPT. They have sought to set out how those aspects of IAPT might affect counsellor's professional development.

Chapter 5: Discussion Chapter

5.1 Introduction to Discussion Chapter

In this chapter, I discuss the findings of this research, situating those findings alongside the participants narrative, whilst blending the published literature into the discussion. There were three identified themes, each of which has or had influence on the participants professional development, raising implications for counsellors who work, or may work in IAPT. The research question was: *What are the Professional Development Implications for Counsellors who have Worked in the English Improving Access to Psychological Therapies (IAPT) Programme?* This chapter will integrate the aims of: understanding the degree to which counsellors engage with opportunities for professional development in IAPT; how facilitative IAPT service is to professional development; and how counsellors conceptualise and respond to the professional development opportunities available in IAPT. The three themes perform the task of helping to understand those aims by giving the participants experience a framework through which to attach meaning. In this discussion, I have to own my personal lived experience of IAPT. In the role of researcher, I cannot unknow my experience, but by working from the participants narrative, with the literature, and my own experience I hope to achieve a balanced and critical discussion. These elements, appropriately handled, have the added value of enhancing the findings by contributing to the validity and reliability of the discussion. In so doing, the data is not standing alone in the ontological context of what can be known. This chapter also discusses; Limitations of the research; how it might be furthered; original contribution; implications for decision makers – policy and practice; and implications for counsellors. The literature review has demonstrated that IAPT can be placed in the role of being to blame for many negatives relating to counsellors' professional development. The research has identified aspects of this amongst the participants. However, it is worth noting that IAPT was not designed for counsellors; the business model

has no place for counsellors; the clinical model has limited use for counsellors, yet counsellors were inherited by IAPT during implementation in 2008. Some have remained in, whilst some have subsequently been employed on various contracts by services. It is those counsellors who have left IAPT who are represented in this discussion.

The IAPT programme is not straightforward when viewed outside of its paradigm. Counselling is not straightforward when viewed outside of its paradigm, and professional development differs fundamentally and contextually when applied to both paradigms. In true paradigmatic tradition, the two do not serve to support each other. One of the benefits of a thematic analysis is that it provides a framework from which the complexity and dissonant nature of this research can be approached. I sought to make sense of IAPT, and counsellors' professional development; it doesn't make sense! It is not an environment that combines easily to afford an observer the convenience of a straight answer.

5.2 Business Implications

Participants conceptualisation of how IAPT might contribute to professional development, and their engagement in that requires an understanding of IAPT, what it is, what it seeks to achieve, and how it operates. The IAPT business model was recommended by proposing a serious social problem – Depression – along with a solution (LSE, 2006, pp.1-2). That solution was the implementation of NICE guidelines for the treatment of depression and anxiety through the IAPT programme (DOH, 2008). IAPT implementation took place in 2008 across NHS England, prior to which PCMH services operated in a non-standardised approach. This was reflected by participants in interview,

to tell you the truth, whatever we used, whatever approach ... we used many...didn't matter as much as the relationship, really (P15)

In the early part of the 21st century waiting times into PCMH care were not monitored. In my own limited experience, wait times (in extreme cases) could run to as long as twelve months. In 2005, Richard Layard, an eminent professor of economics published articles, papers and a book, proposing a unique approach to PCMH provision (Layard, 2005a; 2005b; 2005c). Layard claimed that a new treatment was available, validated by research evidence, for the treatment of depression and anxiety. This treatment was CBT. Layard argued that the greatest problem in society at that time was depression and anxiety, that many people were debilitated by these illnesses, and that they were not able to work and enjoy their lives. The cost of not treating these people with CBT was financially quantified to propose that a radical new approach to mental illness would pay for itself. The argument was fiscal, in that a person on invalidity benefits of £750 per month could be treated with CBT at the cost of £750 (a month's welfare benefit payment), be able to return to work, the public purse would gain from the reduction of £750 per month welfare benefits, along with an increase of income tax and national insurance contributions from that person. Not only would the person begin to enjoy good health, the public purse would benefit, and all this would be self-funding. It was a bold pitch and it worked. Layard and his supporters proposed and sought an argument and then went on to win it. At which time, one might imagine that they relinquish control of proving the argument they had just won. However, the business of IAPT is all about continuously proving the argument. This lens, through which IAPT can be observed, was not shared with its practitioners. These participants could not see that psychological therapies, under IAPT, had a broader responsibility than helping people. It needed to demonstrate delivering on time, on budget, and to conform to NICE guidelines. This was a major omission in the IAPT implementation strategy. The lack of consideration towards its incumbent practitioners, from a business implementation perspective – the lack of a hearts and minds

approach – left counsellors confused and offended. This is apparent in the following extract from a participant who was unable to accept the need for the IAPT business model,

> *So, the words like treatment plan wouldn't have come into my head. In fact, treatment would have been ugh. It would have been distasteful ... I viewed counselling as first and foremost … you're the person who knows best how you feel and what is best for you (P15)*

Whilst IAPT is a PCMH mechanism for NHS England, it is worth contemplating IAPT as purely a business model - a franchise. This perception of IAPT, by participants, seemed to be on the edge of their awareness. They never really understood the mechanism in which they worked. The following quote demonstrates, despite efforts to explain, the lack of connection that participants demonstrated in relation to recognising IAPT from this perspective,

> *I did go on some of the training about working in IAPT and the philosophy of it and I could see how it worked … all the evidence points to … stick within the modalities and … then it works much better. But then, from my practice, I didn't think that you could just necessarily always, for every single client, do the counselling for depression or being more person-centred. Some people needed something different (P9)*

The National Collaborating Centre for Mental Health (NCCMH) recently published a manual for the use of IAPT services, providing a detailed description of IAPT highlighting three key principles (NCCMH, 2019, p.8),

- Evidence-based psychological therapies at the appropriate dose: where NICE recommended therapies are matched to the mental health problem, and the intensity and duration of delivery is designed to optimise outcomes.
- Appropriately trained and supervised workforce: where high-quality care is provided by clinicians who are trained to an agreed level of competence and accredited in the specific therapies they deliver, and who receive weekly outcomes-focused supervision by senior clinical practitioners with the relevant competences who can support them to continuously improve.
- Routine outcome monitoring on a session-by-session basis, so that the person having therapy and the clinician offering it have up-to-date information on the person's progress. This helps guide the course of each person's treatment and provides a resource for service improvement, transparency and public accountability.

Putting aside the business and medical speak that is used in that description, a first read suggests that there is no apparent reason why counselling and counsellors should not be a thriving aspect of IAPT. Until, the term 'Evidence-based Psychological Therapies' is considered and the use of evidence is considered, not just for client outcome, but for the practitioner and their professional development.

8.3 Evidence-based Therapy Implications

Participants appeared to have a different view of what comprised evidence. Epistemologically they appeared to be intuitive in relation to what can be known. A general understanding of the participants stance on how clients progress can be known, is summed up in this response,

> *depending on whose opposite me, which client I'm with, you know, you get a feel for it, don't you? A sense of what somebody's after or what they're looking for, what they're seeking (P02)*

In relation to counsellors, the consideration of what defines evidence is important to understanding implications for professional development. If counsellors cannot grasp this IAPT epistemological perspective on evidence (that it is just one way of knowing) it can have implications for engagement. In IAPT, evidence is not defined, its meaning is subject to change in line with its compliancy to NICE guidelines. NICE, on its website, explains the principles behind the development of its guidance, and by association its decision making on what is evidence (https://www.nice.org.uk/about/who-we-are/our-principles). In relation to decision making, NICE states,

> *When making decisions, NICE and our committees strive to balance the need to achieve the most overall benefit for the greatest number of people, with the need to ensure fairness and respect for individual choice ...* (Paragraph 4)

A classically utilitarian position mirrored by Bond (2000, p.46), which participants found ethically challenging. In striving to define evidence through such a (utilitarian) mechanism, NICE may create an obstacle to counsellor professional development apropos the aspiration to balance generalised benefit, and fairness, with respect for individual choice. Generalised (nomothetic) decision making, clashes with idiographic values. Participants appeared to struggle to adopt a utilitarian stance. Professional development in such a business and clinical environment could be obstructed by such a dilemma. The next extract, suggests that this participant struggled to adapt to this aspect of IAPT,

Well, this diagnosis you do this – and ignore this … to me that's wrong, that's really badly wrong … if you can work with the other things, and you can integrate, and you can try and meet the need of that person, well to me, it's unethical not to do that (P04)

Achieving this objective, requires the application of a complex spectrum of philosophical mechanisms commonly referred to as ethics. Bond (2000) argues that counselling is a profession provided with a sophisticated level of ethical awareness. BACP (2018) have adopted principles of good ethical practice which reflect the work of Beauchamp and Childress (2019, p.13), who propose four clusters of principles reflective of the moral thinking aspired to by NICE: respect for individual autonomy; non-maleficence (doing no harm); beneficence (doing good); and justice; and Thompson (1990), who discusses fidelity; the building and maintenance of trust; and self-interest, which allows for the practitioner to also benefit from all the foregoing principles. Ironically, the practical application of such philosophical mechanisms demands the quality of tolerance for uncertainty. Uncertainty is a state that positivism strives to negate, often through generalising observations of quantitative data, which creates a challenge for NICE in achieving its stated ends. It also runs contrary to the counselling ideology of respecting individuality, tolerating clients' rate of growth and change. An example of the ability to tolerate uncertainty in a counselling approach, is referred to in the below extract. The business and clinical models of IAPT do not allow for the development of relationship 'in its own time', IAPT expects treatment and projected outcome in set time scales. This challenges counsellor's professional development,

It was really difficult, because I worked on the relational aspect between therapist and client, and it was really tough to actually let that develop in its own time (P06)

Ontologically, counselling encompasses the question of what can be known across a broad range or spectrum. Which enables counsellors to practice within the boundaries of the ethical principles outlined above. When taking an ontological stance of positivism, it can be argued that a practitioner is constrained within the limits of what is observed as real, and therefore, real is definable by observation (outcome data) and validated by a process of generalisation. Unfortunately, NICE do not explicitly own an ontological stance, which again presents issues for counsellors as they have nothing to compare the broad ontological values held amongst the counselling profession with an owned stance from NICE. The idiographic underpinnings of counselling do not relate well to positivism. There is a diversity of methodological approaches, and epistemological stances associated with the social sciences. Counselling related studies, being in nature social science, are commonly qualitative, and varied in methodological approach. The same is not true of medical science. The acceptance by NICE of the RCT as a gold standard for evidence in medical science is generally associated with a positivist, nomothetic worldview. Believing that people's problems can be defined by diagnoses and treated systematically was a worldview not shared by participants. Struggling to understand this position, accept the business and clinical approach of IAPT to PCMH, and engage with professional development opportunity was an obstacle to participants. The next extract summed this up, as the participant had not grasped that IAPT was designed to take away any divergence of approach, and deliver exactly what CBT therapists offered,

> *I also feel it actually takes away a lot of what therapists … can actually bring to the service if you are trying to almost create a service where all therapists are the same. If you have all CBT therapists then you're not actually enabling other therapists to be individual and to offer, you know, clients a choice (P06)*

Whilst NICE do not explicitly own an ontological position. NICE does explain what is considered when assessing knowledge relevant to its work, and its reliability (https://www.nice.org.uk/about/who-we-are/our-principles). However, the search for an explicit epistemological definition is convoluted, the NICE website takes the researcher through a series of links, which suggest (but do not explicitly own) a pluralistic approach to what is knowledge, and how it can be known,

Figure 2. **NICE Principal 6 on Defining Evidence**

Principle 6. Use evidence that is relevant, reliable and robust

19. NICE's guidance and standards are underpinned by evidence. So, we need to ensure that this evidence is relevant, reliable and robust. To do this, we have processes to identify research evidence, determine whether it is relevant and assess its quality. We also work with data providers to ensure the information and data analytics that we use are high quality and robust.

20. For each piece of guidance, we consider whether the methodology used to produce the evidence is appropriate. We recognise the value of traditional 'hierarchies of evidence' but take a comprehensive approach to assessing the best evidence that is available to answer the questions we face. Our process and methods manuals set out the types of evidence that are generally appropriate for different types of question. This can include qualitative and quantitative evidence, from the literature or submitted by stakeholders. It can also include observational data and testimonies from experts.

21. Committees should not recommend an intervention if there is no evidence, or not enough evidence, on which to make a clear decision. But they may recommend using it in a research programme or alongside mandatory data collection, if this will provide more information about its effectiveness, safety or cost (see principle 11).

The NICE process and methods manuals referred to in the above outtake relate to bio-medical research and the use of technologies. Searching the guidance using the search term 'Mental Health' in all but the actual NICE Guidelines results in negative findings. This confirms that these resources are applicable to the physiological, rather than the psychological. In recognising the 'value of traditional hierarchies of evidence' NICE implicitly

confirm that the bias is toward: firstly – an ontological and epistemological hierarchy; secondly, that qualitative evidence is hierarchically less valued than quantitative evidence, by way of the commitment to data collection and analysis, exemplified by the IAPT business model. The use of data to determine service-user outcome and therapist achievement can have profound implications for the professional development of counsellors in IAPT. Collecting and using data in the manner of the biomedical and expecting it to reflect psychological reality from an idiographic perspective, challenged participants. Participants, already ideologically adverse to IAPT, struggled with the use of outcome data to demonstrate a different reality to that which they intuitively perceived. It is unsurprising, that participants struggled to engage with the IAPT professional development opportunities, when the core values and beliefs of idiographic practitioners are disregarded. This participant, wryly explained the data collection and analysis process, which to this participant, dismissed the therapist's opinion,

> *So, you have to give the questionnaire for every session, and at the end of the session … you have to give them a … satisfaction questionnaire … as well … and then, every three months, we were given a spreadsheet to tell us how effective our form of therapy has actually been (P06)*

Opportunities for practice and training in IAPT, conform with manualised approaches, nomothetically compatible with evidence from the literature; submitted by stakeholders (such as IAPT); or observational data, and testimony from indeterminate experts – opening a whole debate around what defines an expert, and how the hierarchy of evidence relates to that question. Therefore, the search for clarification related to how NICE adopts research evidence in matters of psychological therapies is challenging. Relating this to the professional development of counsellors, it is argued that the ontological and

epistemological stance that informs the IAPT programme is biased against a counsellor's clinical knowledge and judgement. Such methodologies do not recognise the ontological and epistemological value of knowledge that informs the diverse, idiographic ontological and epistemological worldviews that support counselling. It makes for an unwelcoming environment for counsellors to work and professionally develop in. This is exemplified in the below comment made by a participant, related to the IAPT demand to work in a defined, manualised approach,

> *I do have a preference for working outside of IAPT, because I feel like it's more autonomous and I feel like it helps, it aids my development more (P03)*

The business implications of IAPT demand that services are predictive in terms of cost and outcome. It seemed alien to the participants, that therapy could be reduced to a mechanistic approach, a mechanistic approach that has great implications for counsellor's professional development. Like a counsellor's professional development, counselling is not mechanistic.

8.4 Command and Control Implications

The means by which IAPT maintains its unique approach to psychological therapy, is interesting and worth considering. It is not to found in service environments, it is founded and recognisable in industry. IAPT as a business model is reflective of a command and control management approach. Participants did not seem to understand the broader implications that this approach to management could have on their professional development. With IAPT, data collection is key to proving the business model success; replicating the model across NHS England ensures that IAPT maintains standards; expectation can be set at predictable levels and controlled centrally; adjustments can be made to the model with a degree of

efficiency, calculability, and control. This extends to professional development amongst its practitioners. Training needs to fit the model to ensure control. Participants seemed to have limited understanding of why idiographic training was not supported. The answer lies in the need for any investment to support the IAPT model. One participant had requested supervision training, the supervision training sought was for an idiographic approach to psychological therapies. Because this did not support the IAPT nomothetic approaches it was declined. The participant shared the disappointment at having been blocked for DIT training and then supervision, not understanding that the aspiration was predestined to fail because it would not suit the program,

> *I even asked if they would put me through in my clinical supervision training, and that was turned down as well, so I had to pay that for that myself (P06)*

It is surprising that this participant did not realise that such a proposal would be declined. IAPT services are uniformly commissioned by CCG and operated by contract holders across England. Counsellors need to understand that IAPT operates in this way, focussed on the need to deliver outcome. Counsellors professional development is subsidiary to this aim. Surprisingly, participants indicated that uniformity is undesirable, particularly with regards to professional development. Most participants valued personal interest over standardisation. Demonstrating this, and perhaps illuminating why IAPT professional development was misunderstood, one participant shared how a pre-IAPT service manager would invest in and allow counsellors to choose professional development topics for themselves,

> *I used to take myself off on all sorts of things, and that I found really stimulating (P10)*

IAPT contractual details generally align the service provider with the requirements outlined in the IAPT Manual (NCCMH, 2019). In this regard the IAPT business model operates, using command and control management, in a similar manner to a franchise. Seddon (2003, pp.11-12) characterises command and control management as representing a logically designed and managed governance approach in which business decision-making is separated from the work itself. Highlighting the fundamental doctrine as being a reliance on quantitative data, "A central tenet of the traditional command and control mentality is management by numbers; it is the means for decision-making". Seddon argues that a consequence of reliance on numbers is that the focus shifts to outcome measures, and that these measures result in dysfunctional behaviours, such as cheating the numbers to fulfil targets, which competes with the requirements of the customer (or NHS service user), distracting workforce resourcefulness and attention from the service-user to survival – not improvement. This was exemplified in one participants feedback, highlighting its impact on the supervision relationship and purpose,

> *somebody might have been in recovery the week before they ended, but then on the last session … not be in recovery. So, the first step was … my supervisor … saying … that last session, could you go through their scores with them just to see … and I felt a little bit uncomfortable doing that (P10)*

Also, the subordination of treatment to data collection was apparent,

> *… it was very unethical ... that the client's wellbeing was not really even on the agenda ... I completely disagreed with ... the way they were doing telephone assessments ... you weren't even allowed to speak to the client about anything, it was just, tick, tick, tick, psychometrics (P04)*

Both of these examples, indicate how professional development through the experience of learning from client interaction is secondary to outcome. The participants did not share examples of management and supervision exploring clinical engagement to develop greater therapeutic insight and growth. Seddon uses examples of command and control management to exemplify his top down management argument. His experience of the UK Department of Health, in relation to the ambulance service, suggests parallel process in the manner by which the worker is controlled from above and lacks flexibility,

> *I noticed that change of any significance is controlled by the top of the management factory, the Department of Health. To get anything done requires substantial persuasion of those who have power but no knowledge … change … would disenfranchise the various specification and inspection organisations … The management factory is healthy and growing as the health service sickens*
>
> *Seddon, (2003, p.206)*

In IAPT, the targets of delivery and outcome are set centrally by NHS England and communicated down to local NHS trusts, CCG, and contract holders. A process referred to by Montgomery (2016) as the McDonalization of psychotherapy, in which efficiency, predictability, calculability, and control are prevalent. It is questionable whether any of the IAPT decision makers – such as David Clark – have ever worked in an IAPT setting, thereby placing them in the category people with power but no experiential knowledge. Gorod, Hallo and Nguyen (2018) describe traditional command and control similarly - a mechanical approach premised on the organisation and environment being stable, orderly, rational and controllable - as is the case in manufacturing products. These are elements which could be called into question when dealing with people, particularly when each individual will have

diverse values, beliefs, and cultural (macro and micro cultural) influences on perspective, and worldview. Sue (1978, p.419) describes worldview as,

> *… how a person perceives his or her relationship to the world (nature, institutions, other people, things etc.). World views are highly correlated with a person's cultural upbringing and life experiences … not only are they composed of our attitudes, values, opinions, and concepts, but they may affect how we think, make decisions, behave, and define events.*

Clearly, there are generalisable elements of all the above aspects of worldview – attitudes, values, opinions, and concepts. Participants shared the view that generalising human experience was unreliable, that there were no stable, orderly, rational, and controllable factors in determining individuals' perspectives on emotional distress. This participant was clear about the therapist's ability to 'know' a client's world,

> *And that would be the first thing I'd say to anyone, ever. You're the person who knows best how you feel and what is best for you (P15)*

Whereas, the IAPT approach generalises, diagnoses and treats from a stance of 'knowing'. It is worth considering, whether those elements of stability, order, rationality, and control exist in local environments, sufficiently to operate a command and control system across PCMH services. With command and control, managers run organisations through a rigorous hierarchy; planning relies on predictability in the processes, and the machinery that delivers the product. In a manufacturing environment this approach can be highly successful owing to the ability to control the processes, the delivery system and the quality of raw material

through to final product. IAPT relies on controlling the processes (clinical and business), the delivery system (practitioners uniformly trained and managed), but not the quality of raw material (the service user with its diversity of worldview), unless by enforcing a system of diagnostic measures (the fitting game).

IAPT business planning relies on a 50% recovery rate. The business of IAPT is reliant upon its success, quantitative measurement facilitated by a strict data collection policy, and outcome focused clinical supervision ensures success (NCCMH, 2019). Ensuring successful outcomes is a critical aspect of selling IAPT, thereby proving that the argument for IAPT, and subsequent support from politicians and policy makers was appropriate. A critical aspect of which, is training therapists to deliver those outcomes in IAPT style. One participant, again not understanding the IAPT managerial approach, reflected the impact on professional development of being non-IAPT trained, struggling with focussing on systems rather than people, and not being appropriately developed,

> *I felt like it was having to concentrate on systems as opposed to people at times; and … the favouritism or bias towards other people being allowed to do [IAPT] courses at the expense of myself. That to me was holding back my development as a therapist … as a counsellor … getting the best out of someone's potential is everything that counselling stands for, yet it felt like it was a barrier that existed within IAPT towards myself as a counsellor and counselling, full stop (P03)*

That counsellors are employed and not appropriately developed in IAPT, being unable to access training on account of their idiographic stance, is an obstacle to development. Seddon (p.203) argues that government ministers, "make demands for results that they can

talk about as ‘improvements’ and deny the existence of, and their responsibility for, any adverse consequences”, such as those highlighted above.

In order to prove the success of the business model, data collection is a key function of IAPT. It could be argued that IAPT (ironically) sub-optimises the access to psychological therapies through its commitment to its business model. In IAPT the delivery of therapy is prescriptive – service users must conform to the diagnoses and treatments that it offers. Counsellors can have issues with the IAPT necessity to reduce emotional distress into categories of diagnoses. Participants shared issues, with the programs use of diagnostic screening of service users access to IAPT. These ideological challenges of engaging with a highly structured system had implications for professional development, in that not understanding the business and clinical models created resistance to change. This participant observed how the previous PCMH approach tolerated diversity, and encouraged counsellors to work with those differences, thereby providing professional development,

> *People with mental health difficulties don't fit into neat squares, and that was always valued in the past, and it was understood that the people working in that [counsellors] were also going to have to sit with difficulties that they will bring back to discussion, that they will keep reading papers, that they will keep learning, that there will be ... growth (P15)*

This prescriptive and diagnostic aspect of IAPT treatment is a necessary facet of a hierarchical business model in which decisions are centralised and therapeutic approaches are determined by generalised knowledge; service-users can only be treated if they present with the following diagnoses listed in the IAPT Manual (NCCMH, 2019, p.8), and reach a self-reported score referred to as caseness.

- Depression
- Generalised anxiety disorder
- Social anxiety disorder
- Panic disorder
- Agoraphobia
- Obsessive-compulsive disorder (OCD)
- Specific phobias (such as heights or small animals)
- PTSD
- Health anxiety (hypochondriasis)
- Body dysmorphic disorder
- Mixed depression and anxiety (the term for sub-syndromal depression and anxiety, rather than both depression and anxiety).

This control aspect allows for the development of a system that can conform to NICE guidelines, ensuring that local management and practitioners conform to procedures and targets; for example, waiting times (the national waiting-time standard) are strictly monitored, as if IAPT was an industrial production line. One participant highlighted how business priorities required 'cheating' to manage wait times, this activity had no beneficial effect on clinical development, therapists were instructed to,

> *[we would] discharge earlier because there was a focus on the waiting lists and the need to bring the waiting lists down (P03)*

As opposed to a focus on how service-users could be treated more efficiently, to reach recovery sooner and reduce wait times clinically rather than mathematically. This behaviour was not accepted by participants as being justifiable. However, it also highlighted the

disconnect between participants engagement in the business and clinical model of IAPT, a disconnect that created obstacles to engaging with the professional development on offer. The command and control approach to IAPT, has implications for counsellors in IAPT service. Conforming to the program requires a counsellor to train in and deliver the IAPT clinical approach. It is an approach that does not match the counselling ideology.

5.5 Opportunities for Professional Development

Since the implementation of IAPT in 2008, NHS England has funded the development and delivery of a number of manualised versions of the psychotherapeutic modalities detailed above. These manualised approaches to therapy support the delivery of the IAPT programme from a business and clinical perspective. This contribution to the business of IAPT has implications for the professional development of counsellors who work in IAPT. Professional development opportunities are (by design) rarely counsellor friendly. This stance can have a demotivating effect on counsellors. One participant in this study, shared the personal disappointment and uneasiness towards IAPT that results from this sense of disconnect,

> *if I felt that there was more opportunity and flexibility for counselling, and developing CPD, and training further in the way that I work as a counsellor … I may feel a little bit more comfortable towards IAPT (P03)*

There are no figures available to determine which of the IAPT courses are most patronised by counsellors, or even if all the counsellors who work in IAPT have been trained in an IAPT compliant modality. The participants of this study, shared experiences corelating access to NHS funded IAPT training with their local employment status. Perhaps surprisingly, not all

counsellors working in IAPT are employed on permanent contracts. Counsellors are employed on various contracts in IAPT services. This differs from psychological therapists who have IAPT compliant qualifications i.e. CBT, IPT, ECfD, DIT etc. The common range of contracts offered to counsellors in IAPT are: Honorary or Volunteer contracts, which are unpaid and do not entitle the holder to employee rights; Bank and Agency contracts (essentially zero hours contracts), likewise not entitling the worker to employee rights; Fixed Term Contracts (a non-permanent contract over a fixed period of time), which entitles the holder to employee rights; and Permanent Contracts, full employee rights with access to all opportunities and conditions of service. The use of this range of contractual choices, in relation to the business of IAPT, can be explained by the need for IAPT services to deliver therapy within the national standards for IAPT services. The dynamics of service delivery, reinforced by the command and control model, and national standards for service delivery make challenging demands on therapeutic resources. As a result, service managers often resort to the use of such non-permanent contracts to temporarily expand capacity when meeting changing demands and business needs. This can run counter to the advice of NHS England, who recommend employing only IAPT trained staff, and support the employment of counsellor's (albeit on permanent contracts) to train in IAPT compliant modalities, "We recommend services employ IAPT-trained staff or train their existing staff in the recognised therapy modalities to expand capacity" (NHS England, 2015, p.10). The practice of training existing staff, along with the benefits of that training, was highlighted by participants in this study. It is summed up by the following participant, who was initially sceptical of training in ECfD,

> *I did enjoy it [ECfD training] and it actually surprised me. I … got more out of it … than I imagined. But really, I went on that to stay employed (P10)*

Obstacles to professional development were not always presented by IAPT. The acceptance of training appeared to pivot on the ideological challenges in relation to participants as idiographic practitioners. One participant, shared the struggle with training in and delivering IPT for ideological reasons,

> *I was being stretched and pushed into something ... when I was working with the poor clients ... I felt guilty for imposing this [IPT model] onto these people (P04)*

However, where IAPT did present obstacles, was regarding non-permanent staff. The business practice of employing non-IAPT qualified counsellors, using non-permanent contracts, such as fixed-term or honorary contracts, appeared to create a Cinderella effect amongst participants. The type of employment contract which a counsellor engages with is a key element of the professional development opportunities that follow. Non-permanent contracts seem to present a blockage to accessing IAPT training funded by NHS England. This participant was very clear about the denial of IAPT training resulting from non-permanent status,

> *There were some people who could apply for the DBT [Dialectical Behaviour Therapy] training and the other one was counselling for depression, but I couldn't access any of those because I was on the bank (P09)*

Professional development opportunities exist in IAPT, they can be valued and welcomed by counsellors. However, the employment status is relevant to accessing training. Beyond the employment status obstacle, lies an ideological challenge as to whether counsellors can adapt to working in an ideologically diverse approach. Navigating implications for

professional development presented by the ideologically diverse program are further complicated by the conflation of business and clinical in delivering IAPT.

5.6 Clinical Implications

> … men are so watchful to censure, that they have seldom much care to look for favourable interpretations of ambiguities
>
> (Johnson, 1756, p. lXV111)

One of the premises that supported the proposal to adopt IAPT was formulated around a sense that PCMH services did not deliver predictable clinical outcomes. A negative perspective on ambiguity and intolerance of uncertainty was leveraged to promote change. The lack of (pre-IAPT) outcome data made for ambiguity in assessing fitness for purpose. One of the original criticisms of pre-IAPT PCMH was that counselling was an unproven approach and CBT (a proven approach) was an underemployed therapeutic intervention with reliable outcome predictors,

> *The typical short-term success rate for CBT is about 50 per cent. In other words, if 100 people attend up to 16 weekly sessions one-on-one lasting one hour each, some will drop out but within four months 50 people will have lost their psychiatric symptoms over and above those who would have done so anyway. After recovery, people who suffered from anxiety are unlikely to relapse. With depression, there is always the possibility of relapse …*
>
> *LSE, 2006, p.6*

In terms of the clinical environment of NHS England PCMH provision, there was no identifiable support for this claim. The generally acknowledged author of the Depression Report, Richard Layard, has – according to Pilgrim (2008) – a writing style that reflects argument through the use of, “bullish empiricism” and, “elaborate facts” that encourage, “an uncritical trust in pre-existing bodies of knowledge” (p.250). For example,

> *We have drugs that will end a depressive episode within four months for 60% of sufferers. And we have therapies (especially CBT) that will do the same as a result of a weekly session. Once the episode is over, relapse is less likely if the sufferer received CBT …*
>
> *Layard (2005 b, p.20)*

This argument for prioritising CBT over idiographic approaches, based solely on quantitative data, was cause for contention to participants. Whilst, this argument focussed on the ideological and clinical, the outcome had a dominating effect on professional development for psychological therapists in IAPT. One participant had come to understand the business and medical aspects of IAPT and how they conflated to undermine counselling in the program,

> *My experience was exactly that really there’s CBT. If there was a hierarchy of what was, what seemed to impress the business model and the medical model of it, CBT fits very well within NICE guidance (P03)*

The professional development implications that follow from this position, were not recognised by participants and it is questionable whether counsellors in general understand

this issue. The follow on, to a statement such as the one above, might very well be – so, train in CBT if you want to work in IAPT.

In professional development terms, CBT being the dominant modality in IAPT, it is worth considering what CBT means to the IAPT program. The approach that IAPT employs for CBT relies on the application of a manualised response to diagnosed service user need, described by Binnie (2015) as a prescribed version of CBT. The IAPT model of manualised therapies have a distinction over other approaches. In IAPT each practitioner is uniformly trained and supervised to deliver interventions recommended for a particular diagnosis. This uniformity promises that – like a dose of medication – each service user across NHS England receives the same treatment and that the dose can be reduced or increased to match need. The model (by implication) accepts that up to 50% of service users will not recover but recognises that improvements in symptomology will be recognised in up to 70% of service users. In order to make such claims, a nomothetic ontological and epistemological approach must be relied upon. Ambiguity is not borne comfortably in such a system, management and clinical leads are watchful to censure. Such censure, is a product of a centralised command and control approach. Local clinical decisions are strongly influenced by central dictates. Generalising emotional distress, and taking clinical decision making away from the therapists and supervision presents counsellors with an obstacle to therapeutic development.

Since the implementation of IAPT (DOH, 2008) there has been continued and robust opposition (predominantly from the counselling profession) to the decision to locate the treatment model in a medicalised paradigm. This was reflected by participants, one of which was deeply disappointed to be confronted by service resistance to therapists and supervisors delivering ECfD as a non-medical approach,

I was hoping … that they would see the logic of having CfD supervisors, and CfD therapists, and that clients could opt to come into counselling and not have to be clustered; they opted for the non-medical approach, and all would be hunky dory and we would have a fantastic service that was really showing choice – They [IAPT] weren't buying that (P16)

Marzillier and Hall (2009) voiced concern that the IAPT programme was predicated on an over simplified analysis of mental health problems. Suggesting naivety, in its assertion that mental illness can be cured. They argued, that "anxiety and depression are better understood as a part of human experience, not necessarily a pathological condition or illness" (p.397). Pilgrim (2011) highlights the overriding self-confidence and dogmatic adherence to the positivist lens of knowledge that underpins the case for the IAPT programme within the Depression Report (LSE, 2006). Rizq et al. (2010) highlighted a concern that the roll out of IAPT did not fully recognise the complexity and intensity of client need outside of the world of training, and academia – in the real world of delivery. All points supported by the participants experience of working in IAPT. This clinical incongruity, between counselling and the IAPT approach, is an issue that counsellors need to consider. This participant, passionately described the frustration of stating the clinically obvious, from a position of lived experience, that echoed the above authors academic observations,

I think a lot of people who do counselling want to work outside the medical model … because labels and things can be very reductive. So, that kind of medical model … this is what you do, A, B, C, D, it doesn't work as a whole, because people are so much more complicated than that (P04)

These examples, summarise the tensions of the clinical approach adopted and delivered through IAPT. It is little wonder that participants struggled to adapt to ideological change and benefit from the professional development opportunities in IAPT. Ideological resistance is reflected in the literature. House (2012) references the ideological value systems of counsellor's versus, the NICE supported, evidence-based practice, and audit culture of the NHS adopted by IAPT. Guy, Lowenthal, Thomas, and Stephenson (2012) argue against psychological therapy as a prescriptible drug, as opposed to a dialogue; accusing NICE of interpreting patients experiences as symptoms, indicative of diagnosable conditions to be treated. Rizq (2012) highlights the dangers of a system in which tolerance of uncertainty and doubt is supplanted by an organisational intolerance of ideological diversity. These ideological differences between counselling and the IAPT clinical approach can extend to clinical conflict in the reduction of personal experiences to categories or diagnosis. A point made by Casemore and Tudway (2012, p.16) "A significant issue with some of the CBT's … is the tendency to operate from the position that the fundamental model of pathology is both central and correct. In other words, treatment must fit diagnosis". Tolerating (even respecting) unlimited possibilities in the interpretation of human experience is commonly exercised in the idiographic approach to psychological therapy. The IAPT clinical model cannot operate effectively without diagnosis, formulation, and a treatment plan. Counsellors who cannot adapt to that model will struggle to benefit from the training offered to support that approach.

Clinical approach in IAPT is designed to complement clinical outcome. The model observes the approved clinical modalities against outcome, using an overwatch of local service-based data analysts and NHS Digital (who collate and interpret clinical data from IAPT practitioners). Their findings are disseminated to local management, CCG, and NHS England (with public access) on an annual basis. Service-based data analysis is shared with management and practitioners on demand. This data can affect professional development,

because IAPT therapists (of all modalities) are exposed to these external evaluators through the data they collect. Participants referred to the pressures of data collection and its use, clinically and from a managerial non-clinical perspective. Interpreting the results of data collection could be seen as a judgement on their clinical ability and/or the efficacy of counselling, affecting professional self-esteem. The data collected by IAPT services is uniformly used across services in clinical supervision to validate (or invalidate) clinical efficacy amongst practitioners. This is exemplified in the following participant extracts, in which it was interesting to see how numbers can affect counsellor's perception of themselves as practitioners,

> *So, on the machine ... I'm not boosting myself up - but, you know, the work went well, the clients did well ... I used to have good scores – but I didn't fit in the model ... counselling didn't fit in the model (P15)*

The positivist lens through which success was evaluated – the mean, had no recognition of the meaning which individual service users attributed to their treatment,

> *… when I was having the managerial supervision ... my recovery rates were ... quite poor, which ... was quite demoralizing ... even though my manager was really nice and even though both my clinical supervisor and my manager said that they recognized that I was a good counsellor ... being asked about your recovery and being given a percentage ... it did impact on my own view of me as a counsellor (P09)*

This quantitative, nomothetic lens, through which to observe the performance of IAPT intervention in PCMH, is anathema to counsellors who work idiographically. Ironically, the counsellor relies on a qualitative (narrative) process to facilitate ongoing exploration, formulation, and management of the client's distress; often referenced as being the primacy of the relationship. The NHS also collects end of treatment patient experience questionnaires that seek to capture a service users' appraisal of their treatment experience. These qualitative questionnaires, which represent a rich source of data, are not analysed, therefore not considered in the assessment of a counsellor's performance. The lack of balance between the mean and the meaning demonstrates the IAPT disregard for idiographic values.

At an early stage, an attempt was seemingly made to address post implementation tensions, with the publication of a document outlining the relationship between IAPT and counselling (IAPT, 2009). Counselling was recognised as a NICE recommended treatment for mild to moderate depression, having (at that time) in excess of 7,700 accredited practitioners, employed in half of GP practices nationally. Regardless of the apparent credibility and validity of counsellors already in PCMH service, the IAPT position was to explicitly limit the clinical scope of counselling in PCMH, encouraging counsellors to extend their skills by training in CBT. Some participants, objected to the continued prioritisation of CBT as a clinical approach. One participant, a psychodynamic practitioner, despaired at the lack of promotion committed to the other IAPT modalities beyond CBT,

> *I would like to see counsellors and psychological therapists … offered DIT training or counselling for depression, or whatever it is, to enable them to work in the best of their ability for their clients … rather than, just CBT (P06)*

Montgomery (2016), suggested that IAPT had adopted (some may say appropriated) the phrase ‘evidence-based practice’, to support and validate its model, implying that other (not evidence-based) approaches to psychological therapy lack validity. The term evidence-based was not always understood by participants. It seemed to be a naïve or superficial grasp of what NICE and IAPT promote as evidence-based. The following participant, appeared to lament the loss of intuitive evidence, believing that evidence-based was focussed on individual case data collection, as opposed to a broader epistemological stance at an academic level,

> *recovery was becoming evidence-based, which is what IAPT works towards. Whereas before, although it wasn’t IAPT … it wasn’t evidence-based in terms of psychometric scores, there was an evidence prior to that where I could, you know, there was a feel that there was a recovery from the person (P03)*

Participants, and doubtless counsellors generally, would benefit from knowing what ‘evidence-based’ actually means. It might contribute to counsellor’s planning of a personal professional development strategy. The authority, behind the evidence-based practice phrase is provided by the National Institute for Health and Care Excellence (NICE), and whilst 'evidence-based' is often referred to by NICE, perhaps unsurprisingly for that organisation, it is not defined. The NICE Charter (2013) offers insight into the process of deciding what is evidence-based, referring to a number of core principles which include expert opinion, and public consultancy. However, NICE is seen as an ontologically positivist organisation adhering to empirical (or observable) evidence (Williams, 2015). Guy, Lowenthal, Thomas & Stephenson (2012) challenge the process, and ontological stance adopted by NICE in relation to mental health, which determines what is evidence-based practice, citing the epistemological bias towards positivist biomedical values. At this stage it

may be worth reflecting on the effect these tensions can have on counsellor's professional development. During the study, participants reflected on the formal, and informal values of professional development attributable to the clinical approach of IAPT. Formal training was offered to some, though not always aligned to the counsellor's preferences. The following participant, in order to expand knowledge and skills, opted to engage with a lower intensity model of CBT,

> *I wanted to get more insight into CBT [so I secured] a PWP, which is the Psychological Wellbeing Practitioner course (P03)*

Whilst, another participant, declined the offer of this lower intensity CBT training, seeing this level as being a step backwards in terms of professional development,

> *… at one point I was offered … PWP training ... I saw that as a retrograde step (P02)*

Clearly, some counsellors will be willing to make compromises to their professional development plans, whilst others will not.

IAPT provides and encourages training in IAPT approved evidence-based treatments. However, there appeared to be little consistency in the offer from services to facilitate training for the participants they employed; suggesting that counsellors cannot expect uniformity across services of the commitment to counsellor's development opportunity. Counsellors appear to be the most underdeveloped amongst the practitioners of IAPT. Whilst there was, and still remains resistance to the IAPT approach, it is hard to believe that

7,700 accredited counsellors in PCMH pre-IAPT (IAPT, 2009), would have foregone the IAPT clinical approach to therapy in favour of the loss of employment when offered training in models such as IPT, ECfD, DIT, EMDR, or CBT. IAPT offers these approaches as a means to offer counsellors a route to compliancy with its model. It appeared that local service decision making had prioritised CBT as a priority over other these other approaches making it difficult for participants to access professional development. One participant, post-IAPT, had been involved in training ECfD. This participant gave insight into the passion with which counsellors had engaged when training was appropriate to their core approach,

> *I'm working with qualified practitioners, supporting them to get employment and maintain their employment in the NHS, but also developing the scale … enabling a … broader research into the approach [ECfD] and that's very exciting (P16)*

It was surprising, and a shame that local services had not recognised and encouraged the participants to engage, through the training available. The lack of service commitment to counsellor development nationally was reflected by the same participant,

> *I'm agitating to get services to send us more people to do the supervision training so that people could be supported … in their work by a person-centred supervisor … the evidence … shows that that has had a benefit, not only to the counsellors but to the client work and the outcomes (P16)*

Lack of training opportunity in IAPT clinical approaches is a contribution to the counsellors' professional development dilemma. Participants had shared aspects of local managerial relationships that had implications for their professional development in terms of access to

training. Chief amongst these appears to be keeping the participants waiting in anticipation of training opportunity. These opportunities, invariably did not materialise. Counsellors should be aware of the prevalence (nationally) of managers engaging in behaviours that can be ascribed to psychological contracting. These relational behaviours can, and in this study did, present counsellors with obstacles to achieving their professional development aims.

5.7 The Psychological Contract

Anderson and Schalk (1998) highlight that, organisational change situations can have consequences for the pattern of expectations between management and employees, and that the concept of psychological contracting – distinct from the legal document that forms the employment contract – is often overlooked. The pattern of expectations is explained in the following extract,

> *Organizations set demands on the job performance of employees, based on multiple and varied notions of what an employee is obligated to do and not to do whilst at work. On the other hand, employees also have multiple and varied notions about what the organization should be providing them with. This may include, for example, job content, job security, training and development, rewards and benefits, and future career prospect*
>
> *Anderson and Schalk (1998, p.637)*

In transformational environments (arguably the implementation and continued delivery of PCMH services through IAPT) the greater flexibility, mobility, and personal commitment required of management and employees can lead to issues. The concept of psychological contracting becoming rhetorical, as opposed to commitments to each other, is common. A

seeming ‘win-lose’ rather than ‘win-win’ in terms of professional development. This was observed in this study. It appeared from participant feedback that the advantage rested with management, as the party empowered to reward employees. The pivot of power (or the carrot to the donkey) being training and qualification in IAPT approved modalities and/or permanent employment. Participants referenced this phenomenon through their commitment to helping management achieve successful service delivery with the assumption that they would be rewarded. The rewards centred on job security, training, professional development, and the prospect of a future career. The win-lose was evident in this extract. The participant worked tirelessly to impress management, over months, with an expectation that was set and maintained by management. The end result was that the participants expectations of reward never materialised,

> *I didn't get a job – obviously! That was blown out the water … I really thought that I could show them what I could do, and how conscientious I was, and that would stand me in good stead, but obviously, ultimately it didn't (P02)*

Psychological contracts are distinguished between two aspects: Transactional - being work related; and Relational - linked to the personal life of the employee. The distinction between the work and relational aspects of psychological contracting may have a unique complexion when applied to counsellors. Various studies have alluded to the combination of counsellors professional and personal selves in the process of counsellor development (Stoltenberg & Delworth, 1987; Ronnestad & Skovholt, 2003; Du Preez & Roos, 2008; Kern, 2014). Moss, Gibson, and Dollarhide (2014, p.3) determined that, “Professional identity is part of being a counsellor … and is the integration of the professional self and personal self”. This was echoed in the data by participants; for example, this participant highlights the connection between professional and personal self, in relation to training needs,

I've wanted counselling-specific training because that's really my foundation as a therapist and fits better for me as a person (P03)

It is worth considering, to what degree psychological contracting could affect the relationship between management and counsellors from a clinical perspective. Any managerial decisions based on the clinical approach, be that the delivery of psychological therapy or training, may be perceived by counsellors as personal violations of the psychological contract, a conflated rejection of the personal and professional self. In short, the boundaries between a violation of professional self and personal self could be dangerously narrowed in counsellors. Perhaps, resulting in counsellors feeling rejected or violated on both a personal and professional level. In the following extract the participant expresses confusion and confliction following a lack of success in a job application. This participant, a counsellor employed on a zero hours contract, attributed the lack of success to being a counsellor,

After I'd not got the job ... she said we will be fine with your bank work, and I carried on for another two years ... part of me feels like I wish I hadn't applied for it … not getting it ... affected the way I valued myself in that I felt a sense of rejection (P09)

Counsellors should be aware of the process of psychological contracting (particularly in relation to IAPT service) as regards their professional development aspirations. IAPT service managers in this study were observed to use psychological contracting to keep counsellors working at an optimal level. The participants, believing that ad-hoc conversations and agreements regarding their commitment to the service outcomes would be respected, and permanent employment and/or training would be delivered. In many cases these 'contracts' did not materialise.

5.8 Clinical Development

It appears that in IAPT, professional development can be separated between the formal and informal. Some participants, report being afforded the opportunity to engage in specific IAPT funded, formal, professional development, such as training in IAPT supported modalities, and also clinical supervision training in those models. The positivist bias in clinical approach requires counsellors to adapt ideologically or face isolation. The participants in this study reported varied experiences of access to and valuation of those opportunities. Access directly corelated to employment status. Those participants on permanent contracts of employment had access to training in IAPT modalities. Those on fixed-term, honorary, and zero-hours contracts reported being unable to access such opportunities. Ideological preferences aside, this employment status accessibility to training, was perceived by non-permanent participants to be unfair and frustrating. This was not always made clear to participants on non-permanent contracts. The following participant, had no understanding of this issue, was on fixed term contract and expecting access to training, suggesting that management were not being explicit in their contracting – suggesting the possibility of psychological contracting,

> *So, what's happened was counsellors were encouraged to apply for the counselling for depression training, but it did strike me as odd that they could apply for it, but I couldn't (P09)*

Those participants employed on permanent contracts, who accessed IAPT training had mixed responses. Some enjoyed and embraced the modalities. The following participant, attributed the ECfD training to greater insight and clinical development,

To pass it [ECfD] you had to be very purely person centred and I realised how powerful it is as an approach, and if you really stick to it, and you really do work in that way, and you don't sort of veer off to get other things involved, it's really, really powerful (P10)

There are other opportunities that fall into a more generic category of professional development for NHS psychological therapists, such as working through interpreters, telephone work, working with specific long-term conditions that affect mood, training in the use of IT equipment etc. Participants, of all contractual status, reported benefitting from these aspects of professional development. This participant, reflected on a formal low intensity training course, but also recognised the informal workshops and courses offered,

I got the low intensity training [a formal PWP training], and any eLearning training ... stuff like that. They weren't all bad, the courses. There was ... working with different conditions, there was certainly some good training, for example, there was one with working with interpreters ... that was really helpful (P03)

All the participants refenced their informal professional development. There was clear value given to the experience and knowledge to be gained from working in IAPT. One participant referred to this as learning through osmosis,

I wouldn't necessarily say that I intended to become a solution-focused counsellor ... I've not sought out any solution-focused training, but, by virtue of ... going to meetings ... supervision groups, or supervision sessions, you've ... got to know the

way other people are working and ... pick that up by osmosis ... from the environment (P09)

Examples of informal professional development, may not have been immediately apparent to participants but accepted as development through post-IAPT reflection. In some cases, participants had experienced the imposition of unwelcome working practices, such as time management, or note keeping that have enabled them to develop unexpected skills. This participant was clear about the value of such professional development, from a post-IAPT perspective,

From a professional point of view, I think it's really helped mould who I am in private practice … my record keeping … my general professionalism, has been enhanced by working for IAPT (P02)

Counsellors have always recognised that there is work and unpaid work, and that paid work is at a premium for counsellors. However, the unpaid contracts also added something in terms of value to participants. So, it is worth considering that informal professional development is available and beneficial to counsellors in IAPT. Whilst qualification in alternative modalities enhance employment prospects, the experience, skills, and knowledge of having worked in IAPT can be monetised to the benefit of the counsellor post-IAPT. Participants reported on the effect of carrying large and/or demanding workloads (commonly high intensity practitioners will be expected to book 6 clients in a 7.5 hour working day). An example of this challenging (if not punishing) workload was outlined by one participant,

they would expect you to have at least six clients per day – you had three clients in the morning, three in the afternoon, but then because of the waiting list, they also then wanted you to add more clients into your day in case people dropped out. So, you could end up having seven clients in one day and still have all the paperwork (P06)

The above extract does not outline the 'paperwork' referred to, which would be: complete data collection tasks; maintain contemporaneous clinical notes; arrange and re-arrange appointments, along with other associated administrative tasks. Administrative tasks, and exposure to and maintenance of clients with more severe and enduring mental illness, along with management and treatment of chronic risk are classic examples of the clinical issues to which all IAPT practitioners are exposed. Whilst the lack of ideological and clinical alignment between counsellors and IAPT can present challenges, these experiences and skills, associated with the development of a high degree of professional resilience, are recognised and valued by external employers. The post-IAPT growth, and recognition of the value of learning and skills acquired through IAPT has been referenced to varying degrees by participants, for example,

As soon as I came out [of IAPT] because I had so much experience; I'd managed to get my accreditation as well, ... people come to me to get me to work for them. EAP's ring me up ... I don't need to do other things to get work. I mean, that's been really healing, because I have needed healing (P04)

It was clear that counsellors in IAPT can benefit from the clinical development that is available. If counsellors are employed on permanent contracts of employment, their opportunities are greater than those on on-permanent contracts of employment. However, all

the participants of this study referenced value in terms of informal professional development. This encompassed, local service led: workshops and courses in diverse clinical approaches; ancillary skills and knowledge, such as IT skills and experience; administrative skills and resilience. Moreover, the participants referenced the exposure to a broad range of clinical, intensity and complexity of client presentation as being valuable professional development.

5.9 Supervision Implications

The type of supervision to which counsellors are used to is different from the outcome-informed supervision that IAPT provides. This can have an effect on counsellors' professional development. Counselling supervision is part developmental. Outcome-informed supervision runs the risk of being perceived as being a judgementally informed process. Such an approach can be counter-productive to Rogerian therapeutic principles,

> *Evaluation is always a threat, always creates a need for defensiveness, always means that some portion of experience must be denied to awareness*
>
> *(Rogers, 1961, p.357)*

Supervision can affect professional development; in counselling terms it is perceived as a key development activity. BACP define supervision under the Ethical Framework for the counselling professions 2018, point 60, as: [Supervision within the counselling professions]

> *Supervision is essential to how practitioners sustain good practice throughout their working life. Supervision provides practitioners with regular and ongoing opportunities to reflect in depth about all aspects of their practice in order to work as*

effectively, safely and ethically as possible. Supervision also sustains the personal resourcefulness required to undertake the work

[https://www.bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions/]

Hawkins and Shohet (1989, p.4) highlight three functions of supervision: educator; support for the worker; and managerial oversight of the client. Some participants shared that their supervisors, seeking to support them, engaged in coaching them to work in IAPT modalities, thereby fulfilling a role as educator. The below extract, is an example of a supervisor in IAPT, sharing new found skills in ECfD with a participant. It may concern some counsellors that a supervisor would suggest adopting a modality for which a supervisee was untrained, but the participant perceived tis as supportive,

my supervisor was … training for supervising people doing counselling for depression … she recognized from her work with me that I was more integrative … [asking] how it would feel for me to work more like that even though I didn't have training in that (P09)

Page and Wosket (2001, p.19) argue, that to enable fullest therapeutic engagement, development of the supervisee's skills, resources and ability to reflect on the process of therapy is essential. Tudor and Worrall (2004, p.5) provide a broader description, "good supervision encourages practitioners to reflect on their work and to think for themselves". The measurement of the supervisee by a supervisor is not encouraged in counselling, Tudor and Worrall suggest a judgemental approach to supervision may cause counsellors to withhold the congruence required to identify limitations, accept the need for, and instigate

clinical change, fearful of censure and job insecurity. In counselling terms, supervision is a nurturing, supportive and tolerant developmental process. IAPT Supervision is similarly defined by Roth & Pilling (2015, p.4) as being,

> *A formal but collaborative relationship which takes place in an organisational context, which is part of the overall training of practitioners, and which is guided by some form of contract between a supervisor and a supervisee. The expectation is that the supervisee offers an honest and open account of their work, and that the supervisor offers feedback and guidance which has the primary aim of facilitating the development of the supervisee's therapeutic competences, but also ensures that they practice in a manner which conforms to current ethical and professional standards*

At this stage supervision appears ideologically aligned across counselling (idiographic) and IAPT (nomothetic). However, it can be argued (from an idiographical position) that the IAPT business and clinical models encroach upon supervision. This participant, was frustrated by a perceived lack of boundaries in supervision, related to modality. It seemed important to this participant to have a supervisor qualified in the modality of the supervisee,

> *you have to show formulations to your supervisor, who's a different modality, to prove that you're working in a model that you don't even work in! … I mean that's partly why I left because I wasn't going to go down that road (P04)*

Employing supervision, as a vehicle to emphasize the IAPT strategy of quantitative data collection, analysis, and dissemination, could be seen as violating the developmental ethos of supervisors,

> *even though both my clinical supervisor and my manager said that they recognized that I was a good counsellor. Going in and being asked about your recovery and being given a percentage, for me, it did impact on my own view of me as a counsellor (P09)*

The IAPT competence framework for supervision, is a document that presents analogous values of supervision across ideologies, so much so, that it is difficult to argue that IAPT supervision, congruently delivered, is unsuitable for counsellors. However, amongst the competencies championed by the IAPT supervision model is the requirement to use the data collected from clinical delivery in the supervisory process. The IAPT Manual asserts a model of outcomes-focussed supervision (NCCMH, 2019, pp.19-20), outcomes being governed by quantitative data rather than interpretative relational engagement. Roth and Pilling (2015, p.12) caution supervisors in this regard, accepting "That this is potentially complex – information about cases as a whole need to be integrated with quantitative data and it would not be helpful to use indications that a client is not doing well to assume that this means that the supervisee is performing poorly". Engaging with outcome-informed supervision, as opposed to traditional counselling supervision, is not a choice. Clark (2018) asserts that all IAPT therapists should receive weekly outcome-informed supervision. In this study, participants highlighted aspects of outcome-informed supervision, with its evaluative nature, to be reflective of such judgemental practises,

It felt unfair in that respect as a counsellor to be always measured [through clinical data] in that way … I didn't think it gave a true picture of either the patient … or the counsellor (P03)

It is in this detail, that the spirit of caution is compromised from the perspective of counsellors, and tellingly affects professional development in a psychological therapy approach that values – to a high degree – the importance of supportive supervision in the lifelong professional development of counsellors. Clark (2018a, p.177) reflects upon the critical importance of clinical leadership, championing services that had provided therapists with, "personal feedback on the outcomes that they had achieved with their patients, benchmarked against the service average". Clark concludes, that under poor leadership such provision can be burdensome and oppressive, but innovative when delivered under good leadership. It would appear that this league table competitiveness is valued by IAPT. In another paper, Clark et al. (2018, p.685) advocate the positive value of upscaling such data use "Commissioners and clinicians working in the services can now benchmark their services against others and consider the development of collaborative networks …" Whilst these examples exemplify a determination to professionally develop, using managerial, clinical, and supervisory leadership, the limitations and dangers of such an approach are acknowledged. Participants in this study have expressed their frustrations with the supervision model of IAPT. There are implications for professional development involved with the supervision model, if counsellors are uncomfortable with the combination of data and honest, open reflection on their work.

5.10 Counsellors Responses to IAPT

This final section of the discussion chapter considers the way in which the participants of this study have dealt with the professional development issues presented to them through working in IAPT. Being a limited population size, it is questionable to what degree these findings are generalisable across counsellors in IAPT. I suggest, from my own IAPT experience, that it reflects a broad, but not consistent account of counsellor's experiences in IAPT. Crucial to understanding the discussion of how counsellors respond to IAPT is awareness of the environment in which the participants (and counsellors) find themselves practicing. IAPT as a business, and a clinical treatment model has since implementation had a limited use for counselling in its design. This was obvious to all the participants of this study, and has a commensurate effect on professional development opportunity. It was summed up, succinctly, by this participant,

> *I'm not anti-CBT. I think it is a good model. However, it seemed to be lauded over counselling within the set-up (P03)*

Ideologically, neither IAPT business nor clinical models are attractive to idiographically situated practitioners; counselling's presence has always been (and remains) ideologically contentious in IAPT. Notwithstanding, the relationship between counselling and IAPT, counselling, after twelve years of IAPT, is the second most prevalent clinical model delivered at high intensity across NHS England: 20% CBT; 10% Counselling; 4% other high-intensity; 1% IPT; 0.5% Couples or DIT – remaining percentages relate to low intensity approaches (Clark, 2018, p. 163). Furthermore, in terms of success, counselling has delivered recovery rates for depression commensurate to CBT, even when counselling is used to treat generalised anxiety disorder – a diagnosis for which NICE does not recommend counselling. Gyani, Shafran, Layard, and Clark (2013) quote counselling recovery statistics at 50% (the

IAPT target). Statistics such as these, serve to convince counsellors of their professional validity, and the efficacy of their approach in the treatment of mental illness at primary care level, and yet the commitment to the professional development of counsellors in IAPT appears incommensurate to the value of their contribution. The following discussion seeks to illuminate the struggles from the perspective of this studies participants.

5.11 Counsellors Decision Making About Professional Development

Participants, described both active and passive attitudes and behaviours towards their professional development in IAPT. These attitudes and behaviours can be summed up by the term agency, it is the capacity of a person to act in a given environment. In this study the two categories of agency observed, active and passive agency, would be described thus: active agency would describe a participant actively engaging, or actively not engaging with the IAPT business and clinical constructs i.e. the IAPT programme, its professional development opportunities and structures. Participants, did not only access development opportunity from a formal perspective, but also informally. These decisions were mostly made by the participants themselves as opposed to a mandate from management, thereby allowing for active agency - particularly regarding local training opportunity. The following participant had been denied formal opportunities through IAPT, but had chosen to capitalise the local courses and workshops available. Of itself, this was a professional development strategy – to make the most of any courses on offer,

> *Because I was bank, I couldn't access paid courses that other people were going on. But, having said that … a sort of advantage was that … there was free training put on. So, any free training that was put on, I did go and attend (P09)*

Active agency, was also observed to result in negative contributions to development, such as when this a participant seeking to understand and clarify issues during a training course, was subjected to a negative response from the trainers,

> *Everybody had to do the cluster training … I asked questions which I framed within the context of my ontology of the person … this came up two or three times. I was the only counsellor in the room of about 20 trainees, 2 presenters, and I was the only one voicing questions. At coffee break, I was asked by the trainers to come into the side room and they asked me to leave, that I was being disruptive (P16)*

In this discussion, participants are not defined by their agency. Agency is merely the expression of a decision that is informed by the participant, or counsellors' values and belief systems in the context of the opportunity presented to them. Maxwell-Smith, Conway, Wright, and Olsen (2018) discuss consumer decision making, exploring ideological influences on consumer choices. Relating this to counsellor's professional development in IAPT (and framing IAPT practitioners as consumers of professional development opportunities in IAPT), the topic of ideology is worthy of comparison across the academic fields of consumer decision making. IAPT takes a NICE informed utilitarian stance, whereas counsellors display idiographic values. Maxwell-Smith et al. contrast utilitarian approaches to understanding consumer decision making behaviour with value-expressive approaches, arguing that value expressive approaches are difficult to generalise due to their reliance on emotion, or personal values, versus utilitarian pragmatism – thereby reflecting an idiographic stance. This was observable in the data, participants making value expressive choices around the delivery of therapy over IAPT clinical (utilitarian) directives. Take the following extract as an example of a participant exercising value expressive action,

I kinda fiddled the system a bit ... if people cancelled two sessions you had to discharge them. So, I used to not put all the appointments on the system (P10)

In exploring agency on the subject of professional development choices in IAPT, it can be assumed that participants may have been guided by their value expressive ideological stance, rather than a utilitarian pragmatism. Such a concept may illuminate counsellors' refusal of and resistance to IAPT professional development opportunities, even when engaging with those opportunities would strengthen their employability, and professionally develop themselves. The following quote, sums up the argument for counsellors' ideological loyalties (being value-based) dominating their thinking and decision making as regards choices in professional development opportunity,

Ideologies are defined as value-based belief systems: clusters of interrelated beliefs that express people's values … Values are abstract, trans-situational goals that serve as guiding principles for a person's life

(Maxwell-Smith et al., 2018, p.840)

As such, each professional development opportunity is trans-situational, requiring the counsellor to explore their values and beliefs in the context of the IAPT business and clinical models, and their own professional development needs. Those counsellors who can practice ideological flexibility seem more enabled, and perhaps less threatening in the exercise of agency. This extract, is of interest in that it suggests that the participant, an orthodox counsellor by original training, having worked in IAPT and adopted an open and flexible attitude to values and beliefs, benefitted from an openness to ideological pluralism,

I've changed in the way that I work. I think my awareness of what it's like to work in short-term settings ... why they [IAPT] use the different measures ... I think it was helpful … I did learn from people who use different approaches ... I've always been open to understanding the aim, the different aspects, the different approaches ... why they are valued for working with the clients, and I really did absorb … any learning that I was given (P03)

5.12 Implications of Internal and External Evaluation

Following on from the discussion around decision making, with its emphasis on values and beliefs and relative to professional development, it was interesting to consider how the participants perceived themselves. Rogerian theory, relative to idiographic counselling approaches, places emphasis on the relationship between internal and external evaluation. Rogers, respected the ability to evaluate the self as being a key aspect of growth "By encouraging people's ability to evaluate themselves, I have stimulated autonomy, self-responsibility, and maturity" (Rogers, 1978, p.92). During counsellor training there is a considerable element of time and resource devoted to personal growth, and the development of a strong internal evaluation capacity. Counsellors, as a result, learn to rely on this aspect of self-management in relation to their work, enabling them to distinguish between their own and their client's issues to focus on the client issues. This was referenced by the following participant, who was able to put aside personal issues relative to IAPT, for the clients, but not for the self in terms of the relationship with IAPT,

I mean a key skill of our work is, whatever is going on for you, when you go into that room, you put it to one side and that time is that clients time, and obviously we do that every day (P04)

This key skill, of knowing what is going on for you, and putting aside personal distraction to deal with a task, is also relevant to making personal decisions about professional development. However, the participants did not seem to be able to separate their ideological challenges in order to mindfully progress their professional development needs. It is interesting to consider, that when the counsellor's internal issues are inextricably linked to their relationship with IAPT, it can create personal and professional dissonance. Proctor and Hayes (2017) reference the possible value conflicts for counsellors in IAPT, juxtaposing the IAPT stance of imposing standardised measures, against the irrelevance of a client's perspective on those measures with the counsellors prioritising the relational aspect of the therapy. Raskin (1952) argued that the ability to self-evaluate, facilitates the process of respecting another's internal locus of evaluation, which in turn enables a counsellor to empathise within the client frame of reference, respect their worldview and encourage the client's reliance on self-evaluation. Whilst understanding another frame of reference is a fundamental skill in counselling, there was little evidence of participants being able to respect the IAPT business and clinical frame of reference, or locus of evaluation. In IAPT, the strong, often overpowering, external evaluators created by measures, such as manualised approaches, outcome-informed supervision, NICE guidelines, contractual demands, programme related procedures and policy can and will have an affect counsellor's self-belief. The following participant, highly qualified and experienced, felt worn down by the exhausting reliance on external evaluation,

> *Yeah, I actually thought that I was like a rubbish therapist and I should just not be working with clients, because that's how I felt after four years (P06)*

And yet, another participant shared a powerful self-belief, from which it can be observed that the internal evaluator remained strong, supported by a different set of external evaluators – the clients,

> *I've never been a failure at being a therapist, and I've never doubted … I'm not one of these people who walks around thinking maybe I'm a fraud. Maybe, I'm actually a good therapist. I don't think that. I know I'm good, because the clients tell me that (P04)*

In IAPT settings, the constant challenge of tolerating external evaluation from a business and clinical perspective can be frustrating to counsellors. Counsellors trust themselves, and trust their clients, it seems that they have little trust for IAPT's generalised evaluations. It was interesting to note that none of the participants had used the external evaluations, such as outcome data, as a means of developing themselves. Had no understanding of the value of outcome data being used to validate their clinical value to the services they worked in. Outcome data was always presented as being negative, and with a program that expects a 50% recovery, and 70% reliable improvement it suggests that interpretation of data is used punitively. Counsellors should be aware of the negative implications of outcome data interpretation on both their personal and professional self-esteem.

5.13 Pluralism

In this study, a striking similarity between the participants and their professional development is observable. All but one of the participants referenced having been trained in or introduced to and adopted, other ways in which psychological therapy can be delivered. To varying degrees, participants had owned and valued the use of CBT, IPT, ECfD, and Solution

Focused approaches. Non-clinical development (which was recognised across all participants) aside, the link between the findings in this study and the case for pluralism is worth mentioning. This thesis has regularly noted the different ideological stances between counsellors and IAPT. The counsellors being idiographically situated, whilst IAPT adopts nomothetic approaches to treatment. The participants were observed to recognise, adopt and use nomothetic clinical interventions (such as CBT, IPT, Solution Focused) that they had learned through formal and informal means. What was interesting, was that no participants had suggested the reverse was true, that nomothetic practitioners had been influenced by the counsellors approaches to therapy. This is an observation that corresponded with my own lived experience of IAPT. It may suggest that counsellors when presented with diverse therapeutic methods and ideological values in psychological therapy approaches (most obviously in IAPT) are able and willing to flex ideological stance. They have demonstrated the ability to consider and include (when suitable) learning and development that is outside of the category of idiographic approaches. The ability to professionally develop in such a way could be argued to be pluralistic in nature. Cooper and McLeod (2011a, p 3) discussing pluralistic counselling, argue that "different clients are likely to benefit from different therapeutic methods at different points in time, and that therapists should work collaboratively with clients to help them identify what they want from therapy and how they might achieve it", and that methods traditionally associated with an idiographic approach, such as empathic understanding and responses and other methods that are not associated with idiographic methods, such as Socratic questioning (Cooper & McLeod, 2011b) are indicative of a pluralistic approach. These elements were recognised in the participants of this study. The following extract is offered as support for this assertion. These participants were orthodox person-centred counsellors by original training, both entering IAPT service as counsellors,

I'm on with cognitive behavioural approach, which I learned in IAPT (P02)

I don't have a deliberate bias towards counselling, although I like counselling, and I don't have any deliberate value with CBT ... I'm qualified in CBT ... I'm very open to the idea of using other models (P03)

What is of further interest, is to consider that participants shared these experiences without explicitly owning (perhaps not recognising) a pluralistic stance. I would argue that being able to shift from idiographic to nomothetic interventions, for the clients benefit, requires tolerance of (perhaps even to embrace) an ideological cognitive dissonance. Integrating nomothetic interventions i.e. a cognitive behavioural assertion that negative thoughts on a subject maintains distress, and that those thoughts can be replaced with positive thoughts, thereby reducing or removing that distress, is more than just a 'cut and paste' intervention for those participants – it was a considered collaboration with clients to agree what would best help them progress. This was a considered to be a development of their personal therapeutic models and ideological stance.

That these participants, as counsellors, had developed pluralistically through their exposure to IAPT practices, is worthy of contemplation in terms of the possibilities for other counselling services, such as those in the third sector. Consideration of diverse ideological values and beliefs in relation to ontology and epistemology, may enable the development of counselling's clinical range in relation to what can be treated. In short, counselling services can vie for contracts from CCG, which in turn will expand (and improve) access to psychological therapies, professionally develop counsellors beyond current ideological boundaries, and provide funding from contracts, for paid (even permanent) employment for counsellors. It could level the playing field of employment for psychological therapists – notably counsellors, adding to the debate (both nationally and internationally) that pluralism is a valid therapeutic approach.

5.14 Answering the Research Question

What are the professional development implications for Counsellors who have worked in the English Improving Access to Psychological Therapies (IAPT) programme? In answering this question, it is worth noting that the research relies upon the data shared by the participants, and that further implications may exist beyond the recognition and scope of this study. No clear list of implications emerged from the study, though the themes (unsurprisingly for a Thematic Analysis) were clear. In broad terms, the data indicates that participants had engaged with opportunities for professional development. In this study the professional development that has been identified is separated between clinical development and non-clinical development. This list is not exhaustive, merely reflecting the most prominent aspects of the participants experiences.

Clinical Development would include,

- The development of a pluralistic approach to psychological therapies
- Exposure to a wide range of client presentations
- Clinical skills development in, and experience of moderate to severe mental health presentations
- Broader understanding of and knowledge regarding mental health issues, including the medical approach to mental health
- Development of clinical resilience and confidence

Non-clinical development would include,

- Development and experience of advanced administrative knowledge and skills in the delivery of mental health provision, including the use of patient management systems
- Knowledge of administrative policy and procedures

- Resilience related to the delivery of administrative policy and procedures

This clinical and non-clinical professional development emerged in two ways: Primarily, *Formal*, being recognisable as the training that NHS England commissioned through IAPT to deliver training that resulted in qualifications from higher educational establishments, i.e. CBT Diploma, and Certificate in low intensity treatments for anxiety and depression; and by accreditation from nationally recognised psychological therapy associations such as BACP, i.e. Interpersonal Psychotherapy (IPT), Dynamic Interpersonal Therapy (DIT), Experiential Counselling for Depression (ECfD). Secondly, *informal*, being recognisable as training that individual services provide to practitioners through workshops and lectures, also described as 'in service training', for example working with or through interpreters, recognising severe and enduring mental illnesses, managing risk. There was also a recognised value in an aspect of development that emerged from the data, which has no qualification or provision – *experiential* development. The latter was included in the analysis under the code DEVELOPMENT-FACILITATED-INFORMAL. Whether the latter was considered by participants to be an opportunity is doubtful, but the value of that experience has been recognised by participants mostly on reflection, post-IAPT. It is also recognised that, by the nature of this experience, the degree to which participants engaged with this type of development was largely outside of their influence.

The degree to which participants engaged with formal development opportunity was predicated on two levels. Firstly, the contractual level. Participants who did not have a permanent contract with an IAPT service were not able to engage in formal professional development opportunities. Secondly, participants who had permanent contracts of employment who were able to engage, but may have been denied training for varied reasons, such as managerial preference for candidates, or negative bias towards counsellors. Another aspect of this was participants ideological aversion to the training on

offer. This latter aspect of professional development is an area that counsellors can influence personally. However, it would require those counsellors to consider adopting a pluralist ideological stance in order that they might benefit from the professional development that is available across the range of IAPT training. Finally, those participants who had non-permanent contracts of employment, such as fixed-term, honorary, zero hours. These participants had accessed informal training of the type provided by their particular services. Such training was valued, contributing to positive professional development, but it is questionable to what degree the value transferred into employability in an IAPT setting. It was largely considered to be valued, post-IAPT, by external employers and in private practice.

The findings demonstrate that IAPT service does facilitate professional development. Once more, separated between the formal and informal provision (whilst also recognising the experiential). This is presented as a positive implication for counsellors who have worked in IAPT. However, there are examples of participants who attribute mental and physical ill health, personal and professional dissonance, through stressful experiences particularly associated with managerial relationships. In some cases, this was directly ascribed to being a counsellor. This should not be viewed as a necessary or acceptable cost of working in IAPT, nor worthy of consideration as an acceptable implication of gaining professional development. In many respects the professional expectations of counsellors entering IAPT service have been unmet, and as discussed, the role of psychological contracting needs to be recognised and considered. This is presented as a negative implication for counsellors who have worked in IAPT.

The findings also indicated that participants had varied concepts of what professional development can be, and how available it was to them in their IAPT employment. Some of

the participants experienced frustration related to unmet expectation of their employer's commitment to their professional development. The concept and influence of agency in meeting expectation was evident. There were examples of participants being influential in achieving expectation, whilst others were disempowered or took no agency in achieving their expectation. It was also notable that one participant had no intention of engaging in the professional development offered by IAPT, having a history of self-motivated and self-directed professional development that was personally successful. Those participants who had the benefit of formal and informal training shared a variety of responses to those courses, ranging from appreciation to revulsion. It appears that the participants reflected their idiographic values as counsellors in their preference for development opportunities as opposed to a commitment to the IAPT programme, with its narrower nomothetic and utilitarian approach to professional development. Choices related to ideology are presented as having both positive and negative implications for counsellor's professional development, whilst working in IAPT. There were some obvious negative implications for counsellor's professional development, as a result of working in IAPT.

Negative implications worthy of consideration for counsellors working in IAPT,

- Abuse of trust in managerial relationships through psychological contracting
- Frustration, borne of counsellor's lack of understanding of the significance of the IAPT business and clinical model to the program
- Challenge to personal and professional self-esteem, related to difference in ideological stance between counsellors and IAPT program
- Lack of formal professional development opportunity, mostly evident amongst non-permanent employees, for counsellors in IAPT

The implications for counsellor's professional development in IAPT service are varied, but overall the IAPT programme offers a rich and varied field of opportunity for counsellors' professional development. There are positive and negative implications in the form of ideological considerations, personal frustration, and relational challenges linked to the business and clinical model. It was notable that no data emerged suggesting that the clients of counsellors contributed to these implications. It would appear that the participants respected and protected the client therapeutic relationship, irrespective of their own relationship with IAPT.

5.15 Limitations of the Research

This research reflects the experiences of eight participants. There are limitations as to how representative that is of the greater population of counsellors who have worked or are currently working in IAPT in relation to their professional development. The data from these participants reflects similar experiences, from at least eight services across England (some participants had worked in more than one service) and this is demonstrated in the frequency of codes across the research population.

The wording of the research question '*What are the Professional Development Implications for Counsellors who have worked in the English Improving Access to Psychological Therapies (IAPT) programme?'* may suggest that those implications are finite and identifiable. Whilst it is not considered to be a closed question, a more open question may have been '*Are There Professional Development Implications for Counsellors who have worked in the English IAPT Programme?'* Words are powerful, and this may have had an effect on recruitment, perhaps discouraging interested candidates at a profound level. However, whilst acknowledging this as a possible limitation, the question served to engage enough participants and generate a rich data base.

The research is limited by the use of Thematic Analysis; it is broad brush by nature. Seeking themes will not monopolise the personal aspects of the data in the way of an Interpretive Phenomenological Analysis or expose the personal influence associated with narrative that a Discourse Analysis may provide. However, the data has been robustly collected and managed, which enables its future use in different methodological approaches, and Thematic Analysis has provided a foundation for a subject that has been observed for the first time. In that regard, the study may have suggested that there was a quantifiable answer to the question. There is no comprehensive answer to the question, the findings are themed and therefore offer signposts to further research, and knowledge for counsellors involved with or seeking to professionally develop themselves in IAPT.

An obvious limitation to the research is that the analysis and findings are the product of my own worldview – the lens through which I view the world. In so doing the analysis must take account of my lived experience of IAPT, trusting to the inductive and deductive balance that must be achieved. Whether that presents limitation or strength to the research is arguable. However, that lens has (using the literature and data) been reshaped and polished through this research, and as my perception has changed so too might another researcher bring another perspective to the data.

5.16 How the Research Could be Furthered

The research could be furthered in a number of ways:

- Through a dissemination approach to the research that would begin with submission to peer-reviewed journals, cementing the knowledge in the formal academic literature base. Submission to less formal articles and opinion pieces in association journals and magazines, and presentation of findings at conferences. The range of dissemination would be prioritised to counselling and psychotherapeutic disciplines,

but also with business, management and Human Resources interest. This approach would seek to stimulate interest in the subject and generate further research by others.

- Using the findings of this research to encourage professional associations, such as BACP, to engage and collaborate with higher and further educational establishments to review and adapt counselling training towards a more monetisable outcome for students. A vision of future training would seek to include elective modules on subjects, such as data collection and management, and approaches to therapy that are sought after in the employment market. Universities have and continue to provide IAPT training, and therefore possess the knowledge and skills to offer qualifications in IAPT approaches to CBT, ECfD, and low intensity therapeutic interventions. This training could be included within or offered alongside current counselling training. Thereby, removing the impediment of needing a permanent IAPT contract of employment to access qualification, and empowering students to qualify themselves for IAPT posts.
- Seek support and collaboration of BACP to learn from and adapt the strategy used by Layard and Clark to manufacture political and social consent for a new 'wing' to IAPT. Such a second wave of improving access to psychological therapy, would be the proposal for an idiographically informed extension to IAPT. This would offer a non-medicalised approach to treatment, the aim of which would be to exploit the IAPT reliance on data, by focussing on those service users who do not recover or make significant improvements through manualised approaches – offering an idiographic/pluralistic option.

5.17 Original Contribution

There are two main claims to original contribution in this Thesis as proposed by Phillips and Pugh (2015, pp.74-75). This is the first study to focus on the implications for professional

development of counsellors who work in IAPT. Thereby, setting down a major piece of new knowledge. Also, that this study has encompassed a systematic review of counselling literature to propose and adopt a definition of counselling that differentiates the practice from the IAPT approach to psychological therapy. Thereby, demonstrating an original observation on the definition of counselling relative to this study through a competent piece of research. Added to these two principal claims are a number of supporting contributions that are worthy of a brief mention by virtue of using already known material, synthesising knowledge into the study, to present a newly applied interpretation. This introduces areas that people in the discipline haven't looked at before. The below list supports the originality and strength of this Thesis:

- The effect of a command and control management system (as applied by IAPT) on counsellors' professional development
- The division of the IAPT programme into separate business and clinical entities to observe the effect on counsellor's professional development
- The concept of ideological sectarianism as a consideration in the relationship between counsellors, management, clinical leads, and manualised therapists to help understand division related to IAPT
- The application of a change process theory (Norcross, Krebs & Prochaska, 2011) related to addiction, to the resistance of counsellor's engagement to IAPT professional development
- The application of knowledge associated with organisational psychology (responses to frustration, and psychological contracting) to explain counsellors dissonance and responses to IAPT employment

5.18 Consequences for Policy and Practice

Decision makers in IAPT and NHS England are unlikely to consider the implications for counsellors observed in this research. IAPT professional development is not designed to accommodate counsellors, by virtue of the programme having been designed along nomothetic lines, with a manualised and medicalised ideology. However, IAPT has benefitted from generous government support and funding. If that funding and support were to reduce, then IAPT may wish to consider how idiographically informed counsellors might be encouraged to adapt to the IAPT ideological approach to therapy. Most obviously, through a commitment to developing pluralistic approaches.

The training of counsellors is largely situated in further and higher educational settings. Those providers may wish to consider the implications of this research in relation to the relevance of counselling training to current market forces. IAPT is a major employer of psychological therapists in England. The market for counsellors in NHS England PCMH services is minimal since the introduction of IAPT, therefore an opportunity exists to review and revise counsellor training consistent with IAPT employment needs. Again, the consideration of introducing and developing pluralism amongst trainees could only help further this aspiration.

Professional counselling associations, chief amongst which is BACP, may wish to reconsider their stance on what constitutes professional development in relation to its members. An implication of these findings is that counsellors are irregular and diverse in relation to their approach to professional development. Consideration of a structured approach to professional development may be worthwhile (particularly related to the SCoPEd project) whereby a counsellor can follow a structured professional development plan to achieve an

accredited, recognisable end, acceptable to NHS England as consistent with IAPT employment requirements.

5.19 Implications for Counsellors

There are many applications for psychological therapy; approaches employed to meet client need through counselling are diverse. In IAPT terms, application and approach is clear – offering its practitioners a discernible professional development strategy. Whilst utilitarian in concept, its practicality contrasts with the diversity and irregularity of approach to professional development reflected by the participants in this research. Counsellors working in IAPT and beyond may wish to consider three questions:

- What type of counsellor are you?
- What kind of work do you seek?
- How does your professional develop strategy contribute to those aspirations?

Consideration of those questions may determine whether IAPT is an appropriate and progressive match for a counsellor's aspiration. If IAPT contributes to professional development (or is a career destination) then the professional development opportunities can be capitalised upon. However, counsellors may benefit from understanding and accepting IAPT in its socioeconomic and political context, choosing to use IAPT as a means to their end. This research has illuminated clinical and non-clinical, formal and informal professional development opportunities available through IAPT, counsellors seeking, paid or unpaid, employment in IAPT have a choice; the experience can be the anvil upon which they temper and shape their future, or it can be the rock upon which their aspirations are dashed. I would encourage counsellors to develop and maintain a professional development strategy of their own. Responsibility lies with the individual counsellor, who should know what type of

psychological therapist they are and want to become, in what area of psychological therapy they wish to work, and how their professional development strategy contributes to those aspirations. IAPT will not change for counsellors.

5.20 Summary

This chapter has discussed the data, included aspects of the business, the clinical, and the counsellor's responses in relation to their professional development. Literature has been integrated to reflect participant experience outside of the context of this research. The research question in relation to this study has been addressed along with its limitations. Some thoughts have been offered on how the research might be furthered, along with claims to original contribution. Finally, implications for decision makers and counsellors in IAPT have been highlighted.

Chapter 6: Conclusion

6.1 Concluding the Thesis

This research indicates that there is value in the IAPT programme from the context of counsellor professional development. That value has positive and negative outcomes and was unpredictable amongst the different IAPT services that participants worked at across England. It is perhaps reflective of the idiographic nature, values, and beliefs of counsellors that each participant places different values (appropriate to their own worldview) on their professional development outcomes. IAPT operates a command and control management system, renowned for disempowering its employees. It is a challenging working environment for empowered professionals such as counsellors. However, the benefits of IAPT's formal and informal professional development, and post-reflective comments from participants suggest that IAPT can be used by counsellors to positively contribute to their professional development. What seems most obvious and important is that counsellors must have deliberated on their professional development aims and have a goal in mind, and that working in IAPT is placed in the context of those aspirations.

6.2 Post-Thesis Reflexive Statement

The conclusion of this research offers me a time to reflect on the steep learning curve I have undertaken to complete this Thesis. It interests me that I have only ever wanted to work with adults, as a paid counsellor. Yet, I have been drawn continually towards academic growth and achievement. It is almost 'as if' that part of my self which wants to be a counsellor has been in conflict with another self that wants to validate my work with formal qualifications. I am a confident practitioner of psychological therapies, which in itself is more than enough to power my professional self-esteem. So, I must conclude that this doctorate was about more than being a counsellor, it is about my need to understand, and to share what I understand. In that regard academic research mirrors my work as a counsellor, which I have always

thought analogous to research; one on one, with each client akin to a participant. The findings being a useful insight that clients can take beyond the relationship and continue to develop for their own benefit. I recognise that framing this Thesis as such is oversimplifying the process. What I have developed, is an understanding of this synthesis, of being a confident researcher, combined with my sense of being a confident practitioner – a confident research practitioner. I have decided that this is my goal – to be one. That I will maintain my growth through combining my clinical work with research and writing. This thesis alone has a number of papers for publication.

It greatly disappoints me that since the implementation of IAPT, counsellors are treated as the Cinderella's of NHS PCMH. A flaw in the IAPT strategy was the lack of inclusion, of consultation, the wicked dismissal of the hearts and minds of counsellors and service users in relation to influencing outcome. Even more ironic, a programme devised to remedy depression, anxiety and to support workers back to work, generated the very illnesses it sought to relieve, whilst autocratically replacing so many workers. I lived through those days, struggling to find my place in IAPT. To help make sense of being a counsellor in IAPT, I agreed to write a quarterly column in a professional journal (Appendix.1). I still enjoy reading those columns as I would a diary – I think these days it's called a blog, a clumsy term for such personal reflection. During my doctoral journey, I undertook an analytical autoethnographic study of those experiences (Mason & Reeves, 2018), another completed research and different methodology to add to my research practitioners knowledge and experience. That process was helpful, adding to my growth and giving meaning to my IAPT experience. It also helped centre me for the participant interviews to come. The process of writing and sharing my thoughts, helps to ground me.

This research has been challenging, but I have enjoyed and benefitted from engaging with other post-IAPT counsellors. Being able to share their journey through IAPT has been a privilege. On reflection, I believe that personal agency is at the heart of most things human, that personal agency is, or is akin to what Carl Rodgers identified as self-actualisation. I work hard to exercise my personal agency; it is not easy. I do not always do it well. It is not always welcomed by others. This research has reinforced my view that to nurture myself, I must own my responsibilities to that self. I need to recognise and nurture my personal agency. The counsellors who read this research would do well to consider their own personal agency. Potentialities for positive and negative implications are unlimited when counsellors seek professional development, whether that be from IAPT or other opportunities. The quote offered below from Casemore and Tudway (2012, p.17) sums up and finalises the reflexive bounty of this research from my perspective. I would offer it as advice for any counsellor in relation to their professional development.

Only we can determine our own vocation – You can choose 'who ever'
and 'How ever' you want to be

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Appendix 1. Healthcare Journal Quarterly Columns – 2012 to 2015

MULTICULTURAL MEETINGS IN HARINGEY

RICHARD MASON

I will pose the question: 'Who has the monopoly on cultural knowledge and competence in the mental health arena?' I ask this because I reckon I have spent enough time in self study, attending workshops and courses, working with clients who bring their culture into the therapy room, taking advice and well meaning rebukes from interpreters etc, and yet, as an English, white counsellor I still feel more comfortable when a client looks and sounds like me. Call it reverse cultural complacency if you wish, but when a person doesn't look and sound like me, I think that I actually raise my game a little. I wonder whether clients who are clearly different to me get a better service from me, because the differences between us seem to be more obvious and, come to think of it, even amongst the 'English', as a Scouser, I know that my response to the difference between a Geordie or Cockney client and myself would cause me to 'step up' too.

It seems as if you never can get it right when it comes to cultural knowledge and competence. But that is no excuse for not trying to, particularly in the context of primary care mental health

And it doesn't appear to be any different outside of the treatment room. I remember walking into a Chinese takeaway in a small Scottish town and being enchanted by the 'Chinese' atmosphere; I had walked into little China, all reds and golds and staff in Chinese dress. As I gave my order, the woman looked confused and said in a broad Scottish accent: 'Can you repeat that pal, I cannae understand yer accent.' I behaved appropriately and repeated my order, taking the culture shock on the chin. Another example springs to mind when I found myself with a colleague in a busy canteen in the greater London area and ordered two coffees 'one black, one white'. The black woman sitting behind the till looked at me from beneath her eyebrows and pointedly stated, 'one with milk and one without'. Later that day we called into the café at St Martin-in-the-Fields. I ordered two coffees 'one with milk and one without'; the black woman behind the counter smiled a knowing smile and said 'that's two coffees, one black, and one white'. My wife (a New Zealander) is regularly exasperated when identified by accent as a South African, Australian or New Zealander; it seems as if you can never get it right when it comes to cultural knowledge and competence. But that is no excuse for not trying to, particularly in the context of primary care mental health.

I have been working in my team for almost 12 months now; it's a great team which works in an area that would be fairly described as inner city, socially deprived and multi-ethnic, factors which bring a grand mix of culture and cultural issues into the workplace. I work at an established IAPT service and so my colleagues are predominantly cognitive behavioural therapists by title, but have a rich background of mental health experience that reflects a number of other approaches to primary care mental health. So, I am not the only 'counsellor', even though I am the only one who offers 'counselling' as a treatment to our clients.

With such a rich mix of culture and ethnicity reflected in our referrals, it was, and remains, a major bonus to be introduced to and now administrate our monthly team multicultural meetings. In order to capitalise on the cultural facet of our clientele and better understand our work, once a month, our team spends an hour together discussing a subject that has been proposed by one of our number, linked to their work and which has a cultural aspect that could be of interest to the rest of the team. Usually, the proposer will research the subject and provide a short presentation, prior to an open and explorative discussion of the subject. Subjects that we have covered recently include *Honour killings*, *Perceptions of forgetfulness and client culture*, and *Client culture and the CBT model*; future subjects under consideration are *Cultural aspects of female and male circumcision* and *Cultural assumptions about clients' attitudes to therapy*. The meetings are all about opening up our minds to perceived cultural issues and creating a safe, informed environment in which to explore them.

My team is made up of 15 people with seven different nationalities, within which are a variety of ethnicities and a wealth of cultural knowledge. Having a regular forum for shared learning and exploration in respect of cultural issues is a comforting and supportive resource. So, when it comes to my original question, perhaps it just goes to show that no one person in the mental health arena has the monopoly on cultural knowledge and competence; which leads me to reflect on a Japanese proverb: 'Individually, we are one drop. Together, we are an ocean.' Anyone fancy a dip?

This is the first of a regular column by Richard Mason, primary care counsellor at Haringey IAPT service in London, where he provides counselling and is undertaking an IAPT training programme in IPT. Richard will be providing an insight into his working life as a practitioner within IAPT services. To contact Richard, please email hcpj.editorial@bacp.co.uk

I WISH I HAD SPENT MORE TIME AT THE OFFICE!

RICHARD MASON

I was once told that the most unlikely famous last words would be 'I wish I had spent more time at the office'. I smile now when reflecting upon that comment and a recent period of absence from work. It all began with two weeks off due to a scheduled medical procedure. I had considered the impact not just upon myself and family, but also on my clients, particularly from the perspective of what and when to tell them about the gap in treatment. After all, our professional relationships are extraordinarily intimate, so it would not be feasible to ask a colleague to stand in whilst I was away as a GP or a physiotherapist might. I had decided that it was not necessary to tell my clients anything other than 'I will be away for two weeks' and, so there was no great surprise when I arranged a gap in treatment, to give them four weeks' notice, returning to the subject closer to the time and then again in the session before my absence. Textbook, I thought.

I wonder whether my fellow counsellors reading this have shared the same thoughts in respect of taking time off either for health or holiday?

I have to admit that I was a little uncomfortable about taking the two weeks off, medical procedure or not, especially because it fell not long after the Christmas break and I was due to travel to New Zealand for a long-standing family event not too long afterwards. I rationalised that life happens and that I was not being unreasonable; after all, I would not be taking time off for a good while after all this disruption. Disruption! This 'disruption' was a much valued break over Christmas, a chance to spend quality time with family and friends, to relax, reflect upon the year, reflect upon my spirituality, and consider the year to come. Then would come the medical intervention which would improve the quality of my life and ease the concerns of those close to me, followed by a visit to the other side of the world, where the other side of our family and friends exist, to celebrate my mother in law's 80th birthday and catch up with loved ones that I hadn't seen for over three years. Nevertheless, I considered the impact of all this 'selfishness' on my clients and rationalised that it was not an unreasonable series of events and that times like this contribute to my being the balanced counsellor that I am, with a richness of experience etc.

I wonder whether my fellow counsellors reading this have shared the same thoughts in respect of taking time off either for health or holiday? Have they too struggled with guilt, self-doubt, and thoughts of selfishness? I have, of course, never struggled with these concepts when colleagues have voiced their concerns and, on reflection, I notice that none of my work colleagues struggle with this issue when it applies to somebody else. I have sat at the canteen table and confidently, solidly, espoused my 'silly' colleagues to look after themselves first, in order that they can then look after their clients. It all makes perfect sense and is delivered with a clarity of judgment, thought and vision that is laser-like and unsurpassable. Unless it is me! Anyway, I booked the time off and prepared the clients and it all went swimmingly well. One or two clients enquired as to whether I was 'going anywhere nice', to which I replied that I was staying at home, which was mostly accurate.

I drove home in reflective mood, quite looking forward to my enforced break, with a copy of *The Wire* (Season 2) thrust into my hand by my manager to ensure that I didn't stray too far from the couch of recovery. The procedure went well, I returned home, fired up the DVD player, surrounded myself with books, drinks and biscuits, and settled into organised recovery.

In the middle of the second week, I developed a flu-like virus, was thoroughly miserable, and slept the sleep that delivers no rest; my body just ached. And so began the second round of rationalisation, based on concerns about whether I could actually recover in time for my return to work next week; after all, I had set the expectation that I would be away for two weeks. I told myself: I don't run marathons each day, I only have to get into work and sit there. Questions bounced around my head, such as: what is fitness to practise for a counsellor? How might I be judged by colleagues? What would be the impact on my clients of having another week of therapy denied to them? What would be the impact upon my waiting list, my paperwork etc? So, was I going to be fit to return to work the next week? The answer was 'yeah but no but yeah but no but yeah but no...' and as the time ticked towards the end of the week, I knew I had to make that call to my manager, that call that said: 'You won't be getting your copy of *The Wire* back next week.'

This is a regular column by Richard Mason, primary care counsellor at Haringey IAPT service in London. To contact Richard, please email hcpj.editorial@bacp.co.uk

THE PERSON-CENTRED APPROACH AND IAPT

RICHARD MASON

Helping counsellors to develop and to build up their hours is a practice that members of the Haringey East Team (part of Haringey IAPT Service) have been committed to for a number of years. We have good relationships with a number of training institutions and recently, I linked up with our local college, The College of Haringey, Enfield and North East London (conel), in order to offer three training placements. Conel is a vocational further education college, dedicated to giving the best possible education and training to its students, no matter what they have achieved before. So in my mind's eye, that is an example of improving access to psychological therapies for demanding times, not recognised as a performance measure.

Taking on three supervisees has an effect on a number of aspects of my work, such as my personal caseload, timetable, availability and travel plans between clinics. Perhaps the most interesting and challenging effect has been the need to reconsider the way in which I integrate my person-centred approach to the demands and structure of a busy IAPT service. IAPT was introduced around four years ago, validating the therapies it offered with the umbrella term of 'evidence-based' therapies. Just in case you haven't heard, the evidence-based therapy chosen for the implementation of the programme was CBT, with 'counselling' available for those clients who did not want or might not benefit from CBT. It appears to me that 'counselling' in IAPT has been a 'cover all' term for non cognitive behavioural therapies. Four years on and IAPT has developed and introduced training aimed at standardising the delivery of those non cognitive behavioural therapies. Currently, my understanding of the situation is that counsellors are being offered IAPT specific derivatives of psychodynamic (dynamic interpersonal therapy or DIT) and person-centred (counselling for depression or CfD) along with other models such as couple counselling for depression (CCD) and interpersonal psychotherapy (IPT). It's all go, and say what you will about IAPT, it does and has been delivering more than CBT and is now demonstrably embracing the diversity of psychological therapies; long may that continue.

So when my person-centred supervisees were due to arrive, I felt it necessary to review the way in which I have developed my person-centred approach to suit the IAPT programme. My concerns were that I may have 'gone native' or suffered 'mission creep' and that any guidance I might be about to impart would 'out' me as a 'dirty rotten traitor' to the person-centred approach.

From my perspective, the most obvious tensions with being person-centred in IAPT are presented by the medical model in which the programme exists. So, I felt that I needed to reconsider and revalidate the way in which I behave in the company of clients, whether I refer to those people as clients, patients or by any other description. Also, the administrative policies in respect of communications with GPs – what can be included in GP letters? Who else might read those letters? And the possible impacts on confidentiality from a person-centred perspective etc. The other aspect of integrating a non-medical model of counselling into the medical model of IAPT is presented in the requirement to deal with diagnoses, treatment plans and outcome measurements. I read with interest a recent article in *Therapy Today*[1] by the Chair of BACP, Amanda Hawkins, in which she discussed the difference between counsellors and psychotherapists from an American perspective. Using the American model, the counsellors in IAPT would be termed 'psychotherapists' as we deal predominantly with GP referrals for diagnosed anxiety and depression. Which brought me to the issue that the three supervisees would need to consider in respect of the tensions involved in accepting a person's diagnosis: the fact that their response to that would involve formulating and documenting a treatment plan that can be understood in the medical world! All this whilst avoiding the possibility of going native or becoming a dirty rotten traitor to the person-centred approach.

I set about speed reading my dusty old person-centred text books; such as the ubiquitous *Person-centred Counselling in Action*[2] (perhaps there is an opening for the title 'Person-centred Counselling in IAPT'!) and *On becoming a person: a therapist's view of psychotherapy*[3], in which I noted that when discussing the conditions for psychological growth, Carl Rogers comments that knowledge: 'is tentative and surely incomplete, certain to be modified, contradicted in part and supplemented by the painstaking work of the future.' In that future, our 'now', there seems to be a paucity of guidance available on the subject of integrating the person-centred approach with the medical model that the NHS provides, especially in IAPT, and I hoped that Rogers might have appreciated my painstaking efforts to modify, contradict and supplement the person-centred approach 52 years later in an IAPT service. It certainly gave me pause for thought on how he would have perceived the delivery of modern counselling and psychotherapy.

This is a regular column by Richard Mason, primary care counsellor at Haringey IAPT service in London. To contact Richard, please email hcpj.editorial@bacp.co.uk

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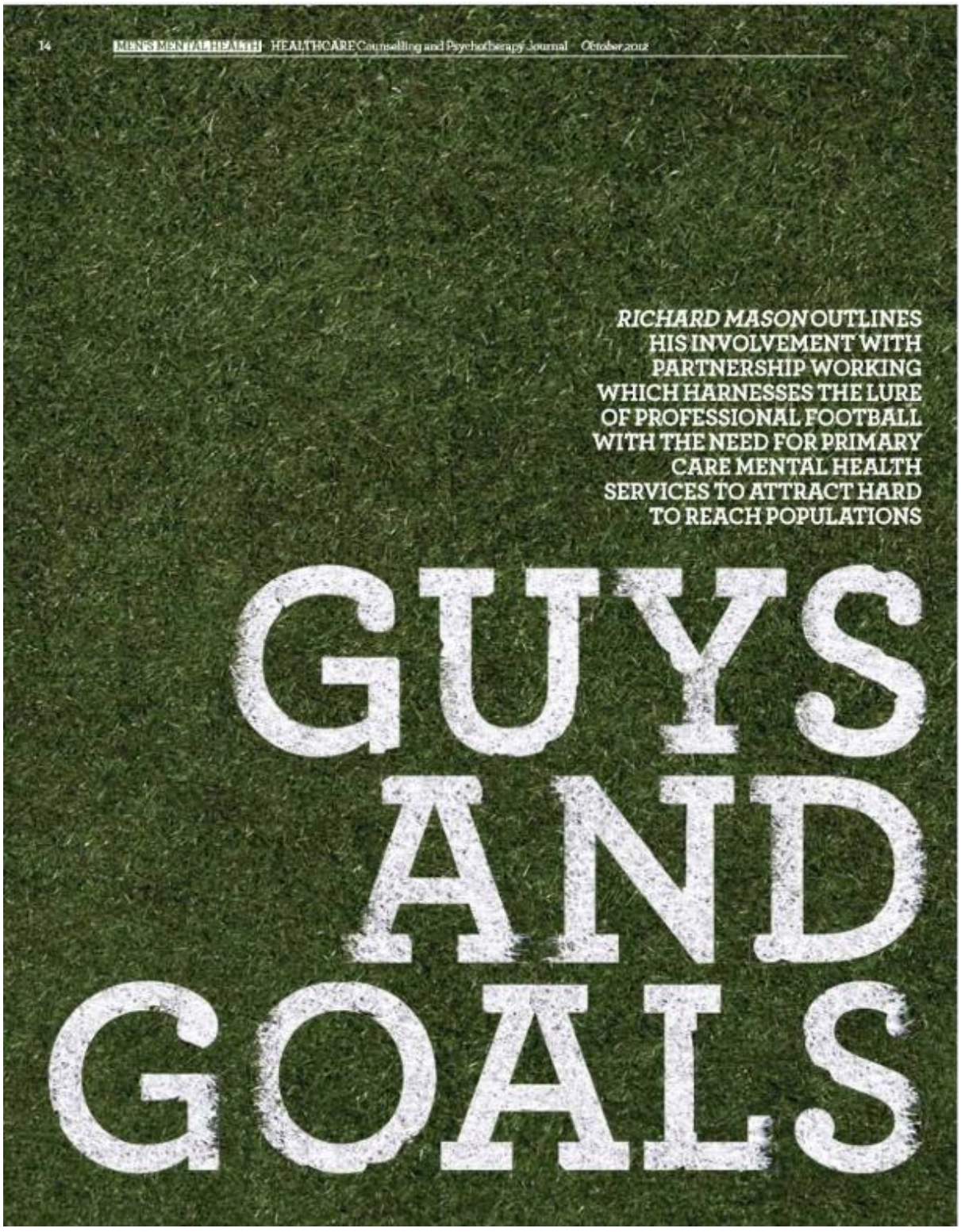

RICHARD MASON OUTLINES HIS INVOLVEMENT WITH PARTNERSHIP WORKING WHICH HARNESSES THE LURE OF PROFESSIONAL FOOTBALL WITH THE NEED FOR PRIMARY CARE MENTAL HEALTH SERVICES TO ATTRACT HARD TO REACH POPULATIONS

GUYS AND GOALS

Many followers of our national sport, which, of course, is football, tend to have a 'second team' which is not their 'real team' but a sort of footballing 'alter-ego'. In my case, as an Everton supporter, I have kept an eye on teams that are in context to my work and my work colleagues: Tranmere Rovers, Blackpool, Portsmouth and Preston North End have all featured over the years. Currently, I am working in Tottenham and passing within 400 metres of the White Hart Lane Stadium every day, so my current 'second team' is Tottenham Hotspur. When the opportunity presented itself to combine my interests in mental health and football on a professional basis via a men's health programme called Guys and Goals, I jumped at it.

The Guys and Goals programme was set up and is run by the Tottenham Hotspur Foundation[1] in Tottenham, North London. Tottenham is a district of the borough of Haringey, a borough which has attracted more than its fair share of negative media coverage over the years. It is an area challenged by a lack of wealth and social problems, often described as 'deprived' and not currently sufficiently advanced in the process of gentrification as to make it hip and desirable to the property market. However, if you were to walk a mile down Tottenham High Street, you would experience a vibrant multi-ethnic, multicultural example of community. In that mile, you would pass through microcosms of the Caribbean, East and West Africa, Poland, Turkey and Cyprus. Sadly, along with and amongst those microcosms of ethnic and cultural variety, come the problems of physical and mental health stigma associated with non–Western and Western masculinity.

ABOUT THE FOUNDATION

The Tottenham Hotspur Foundation has recently celebrated its five-year anniversary and boasts a current portfolio of over 30 projects that have created in excess of 1.5 million sporting opportunities in all sections of the community. These projects help to tackle some of the country's most difficult and challenging social issues and work with a wide range of age groups, from primary school children and their parents to older people living in sheltered accommodation, using sport, and in particular football, as a vehicle to create life-changing opportunities for children, groups and individuals within communities. They achieve all this by working with partners, including central and local government departments, schools, colleges, businesses and charitable trusts. Activities are based on the belief that engagement through sport can result in far more than developing sports skills – sport can harness a sense of mutual respect and trust, widen and challenge horizons, raise aspiration and provide opportunities for people regardless of race, age or gender. The Tottenham Hotspur Foundation works predominantly in the London Boroughs of Haringey, Waltham Forest, Enfield and Barnet and with the Epping Forest District Council, and has undertaken various overseas projects in South Africa, Sri Lanka, Brazil and China[1].

The Foundation recently received global recognition of its work, being placed in the final five in the 'Sport Team of the Year' category at the 2012 'Beyond Sport Awards'. 'Beyond Sport' is a global organisation that promotes, develops and supports the use of sport as a tool for positive change across the world, bringing together the best sport-led social innovators with influential global leaders to address sport's role in driving positive social change. There were 12 categories for the Beyond Sport Awards 2012[2] covering the entire sporting spectrum of health, social inclusion, corporate and social responsibility, and philanthropy. To be nominated in the 'Sport Team of the Year' category, candidates had to display that they had gone beyond increased participation levels by focusing on major issues occurring within their communities. Nominees also had to show the full scope of their 'sport for development' work and a strong connection with the community.

STRIVING TO IMPROVE MEN'S HEALTH

The Guys and Goals programme is just one project delivered by Tottenham Hotspur Foundation, which strives to address the problem of men's life expectancy in Haringey. Male life expectancy in Haringey is below the national average, and even within the boundaries of Haringey, there is a reported discrepancy of nine years between the east and the west of the Borough, with Tottenham being on the eastern boundary.

Guys and Goals attracts men of a mixed age range, 90 per cent of whom are from ethnic minorities, to a weekly exercise programme, coached by Tottenham Hotspurs community coaches. The programme offers men the chance to socialise, exercise and learn about health issues that exist amongst Haringey men. After each training session, the participants receive a 'locker room' talk on issues such as weight management, healthy eating, mental health, male-specific cancers, smoking, drug and alcohol misuse, diabetes, and stroke, among others. In order to fulfil the mental health aspect, I, along with my colleague James Le Couteur (a psychological wellbeing practitioner), offered to deliver a mental health talk and take the opportunity to promote our local IAPT service of Barnet, Enfield and Haringey.

It is a sad reflection that in the three years I have worked in IAPT, both in Liverpool and Tottenham, I have only seen a handful of black men access the services and even less of them have been African Caribbean. I have wondered why this is so, and have nurtured a personal goal of encouraging greater use of services for men in general and particularly black men. The talks that James and I were scheduled to deliver were at Enfield and Tottenham, and, as they were aimed specifically at men in those areas, I reckoned there was a good chance that I would be able to find some answers to my conundrum. It also occurred to me that we might be facing an audience that had as much interest in mental health services as I have in cricket (very little!).

My assumption was reinforced by an email from our contact at the Tottenham Hotspur Foundation who hinted that the mainly African Caribbean participants might be a little turned off by talk of 'mental health' and suggesting we tailor our approach to somehow not mentioning mental health!

DELIVERING THE TALKS

The first talk that we were due to deliver was to be at Oasis Academy Enfield, which is one of a family of Oasis Academies around England, set up to create outstanding schools and community hubs to facilitate adult learning and provide fitness suites, sports halls and out of school hours activities for all ages. It is an impressive venue and so, not wanting to let the side down and taking into account the feedback on the label of mental health, James and I, in our very own interpretation of the locker room chat, kicked the labelling issue around.

Back in the late 1990s I had written an article on emotional fitness which was published in the *Police Review*; it was penned as a challenge to the police service to recognise the value of emotional wellbeing alongside its physical fitness values. The article was ahead of its time, but the 'emotional fitness' title, conceived with a view to encouraging debate about mental health in a macho organisational culture, was as valid then as it is today. For Guys and Goals, therefore, we decided on an 'emotional fitness' rather than a mental health approach.

The programme offers men the chance to socialise, exercise and learn about health issues... After each training session, the participants receive a 'locker room' talk

On the night, we dutifully arrived on time with notable levels of generalised anxiety, introduced ourselves to Tottenham Hotspurs coaches and the participants, and began our presentation. Despite a nervous start, the talk went well. We drew an analogy between physical and emotional fitness, between physiotherapy and psychotherapy, which generated a lot of pertinent questions. It was a free-flowing debate and I found the opportunity to pose my question about black men and access to psychological support. The feedback I received was that black men are emotionally aware and talk openly about their problems – they just talk amongst themselves. It was interesting and a little worrying to note that the group had not heard of IAPT, though they were pleased to hear that they could self-refer to access the service.

The following week, we were to deliver the Tottenham talk at the Broadwater Farm Community Centre, another impressive venue. The centre is managed by Haringey Council. There are two halls, the main hall having a capacity of up to 500 sitting or 1,000 standing; hopefully we would not be a sell-out attraction. Again, we were advised that the mental health label might be a challenge.

When I entered the Centre, I was anxious and alone – at the last minute, James, my colleague, was unable to attend. In the event, I was made very welcome, not just by the Tottenham Hotspur coaches, but also by many of the participants, who made the effort to introduce themselves to me and enquire about the talk I was due to deliver. Feeling a little less anxious, I moved into the tight semicircle of guys eager to hear what I had to say about emotional fitness. It's one thing working one to one with clients and feeling very much in my comfort zone, surrounded by the familiarity of NHS furniture, paperwork, colleagues etc, but out here in the real world, without James to support me, anxiety drifted back. In this anxiety, I blew the emotional fitness approach within moments of opening up – verbalising 'mental health', 'psychological health', and 'mental illness', I used just about every description other than psychiatric (probably just as well) to explain the relevance of emotional fitness to men in the modern world. To my relief, the label of mental health was not an obstacle, particularly when placed into context by the physiotherapy/psychotherapy analogy. The participants listened intently, again asking pertinent questions. Again, I saw the opportunity to pose the mental health services question, receiving the same answer: black men talk openly about their problems amongst themselves. Once again, there was surprise that IAPT existed and that they were able to access the service.

Given that I was on such a roll, I mooted the idea of a men's only emotional fitness group in which participants could learn more about practical psychology and its application to men's lives, including mental illness, self-care, and how and when to access services such as IAPT. The idea was well received and the next question was: what was I going to do about starting a men's emotional fitness group? It seemed to me that the mental health genie was well and truly out of the bottle. After the talk, I stayed around awhile as the participants trained, and was available for conversations. I asked one of the guys for his opinion on how the talk had been received and he was very enthusiastic, agreeing that black men are a 'hard-to-get-to' population and sharing his view that the best medium for encouraging black men to use such services was to get out and talk to them directly rather than leaflet them or advertise.

HELPING TO REDUCE STIGMA

Guys and Goals runs twice a week over a 10-week programme and the second series is currently underway as I write. This year's run has been well attended, and talking with Maria Abraham, health and wellbeing manager at Tottenham Hotspur Foundation, I was pleased to discover that the mental health talks,

delivered by James Le Couteur and myself, were very popular. I asked Maria why she thought this was the case, given that men, and black men in particular, are such a hard-to-contact group in primary care mental health services. *'These are men who don't go to the doctor's surgery unless they have a broken leg or something serious,'* Maria answered. *'The mental health talks are the most popular because your presence gives the men a sort of implied permission to talk about mental health openly, feeling safe to explore issues generally in a relaxed, blokey environment, with a bit of banter.'*

... being comfortable in my own environment is fine, but if I really want to play my part in improving access to psychological therapies, I need to step outside of my own comfort zone and engage with the community

I wanted to know more about what it was about the Guys and Goals formula that helped to reduce the stigma of mental health. *'What you get is a group of men who would never normally have met, because of obstacles around culture, religion, employment, age and so on,'* Maria said. *'I think that makes it easier for them because it removes the obstacles and allows them to open up to the talks as a group, rather than as individuals.'*

Maria's department in the Tottenham Hotspur Foundation focuses on reducing the life expectancy gap in Haringey and improving mental health and wellbeing. The Guys and Goals programme has an impact on both these aims and, whilst measuring the amount of impact may be problematic using academic measures, there can be little doubt about the popularity of the scheme from an exercise and socialising point of view; couple this with the inclusive effect from an individual and organisational perspective, and the model becomes very attractive. *'Guys and Goals is a hub for access and signposting,'* Maria concluded. *'It's the beauty of multi-agency working that we can direct people to services and charities that these men can access, but would not normally consider or even be aware of unless people like IAPT and our other partners came and spoke to the groups.'*

I wondered why Tottenham Hotspur Foundation had such success in reaching this group of men where other agencies, including IAPT, struggled. *'It's the power of football,'* Maria said.

'Tottenham Hotspur Football Club is a big brand name, and that, coupled with the Premier League, which contributes to Guys and Goals through The Premier League Charitable Fund, is a major attraction to these guys.'

LOOKING TO THE FUTURE

As I walked away from my meeting with Maria, it occurred to me that my anxiety around engaging with people outside of my 'clinical' comfort zone could mirror the anxiety that certain sections of our communities experience around engaging with our services. I reflected on this and am of a mind that being comfortable in my own environment is fine, but if I really want to play my part in improving access to psychological therapies, then I need to step outside of my own comfort zone and engage with the community.

Meanwhile, and in answer to the question (or was it a challenge) posed at Broadwater Farm, I have been working with members of the senior management team at Barnet, Enfield and Haringey (BEH) IAPT service and Maria Abraham at Tottenham Hotspur Foundation, trying to identify and secure funding for a men's psycho educational group. We are hopeful that, by working in partnership, we can open up a pipeline between the two organisations, feeding the group from participants of Guys and Goals and from the male service users at BEH IAPT. The service users who attend the group would meet and work with Guys and Goals participants, and in this way we would be building on some of the valuable feedback that Maria observed from the Guys and Goals programme: so that we could become a part of the hub for access and signposting for groups of men who would never normally have met – for the benefit of their mental wellbeing. ■

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[1] http://www.tottenhamhotspur.com/foundation/index.page
[2] http://www.beyondsport.org/the-awards/

READER RESPONSE
The author welcomes feedback about this article. To contact Richard, please email hcpjeditorial@bacp.co.uk

YOU'VE GOT A MYSTERY ON YOUR HANDS

RICHARD MASON

We recently had a visit from 'infection control' and as a result, the building developed a rash of posters encouraging us to wash our hands and to use the hand sanitisers which are situated on our walls. Germs are a serious subject in the National Health Service and, in IAPT, we are not immune to the demands of infection control. We can all see the need to reduce the risk of infection; the conundrum is how to play a full role in making that happen whilst taking into account the needs of our clients.

Back in the pragmatic world of our busy office, I was instantly attracted to a colourful poster that made the assertion: 'You've got a mystery on your hands'. It was a multi-coloured hand print which used colour to code areas of the hand to a list of key places where I might be picking up germs, for example 'elevator button' on the index finger pad, 'computer keyboard' on all four fingers, and 'sweet from co-worker' (oddly at the base of the middle finger!). It took me two days to realise it was 'sweet' and not 'sweat', which then raised the question of whether it was a typo error; even if it was, I suppose both would be valid sources of infection. The poster finished up with a final and stimulating thought in respect of other possible sources of infection: 'Who knows what?' Crikey! Not that anyone is trying to frighten us.

The posters have proved to be a great success in terms of raising awareness and generating discussion amongst my colleagues around the subject, not least in relation to the application of standards that are designed for surgical environments being applied to a psychological setting. This set me thinking about the wider context of 'infection' and how that might apply in the psychological context rather than the surgical context, and most importantly to counsellors and psychotherapists, the emotional baggage or contamination that may affect our lives and relationships.

I reckon that I am pretty well boundaried when it comes to my work and, in keeping with the infection control message, I began to think about those times when I get home and am asked the question, 'How was work today?' This is the kind of rhetorical question which does not really require a full answer. The person who asks it usually expects a quick précis such as, 'Yeah, pretty good/normal/difficult', but there are times when I find myself wanting to say 'I saw this person today...', and it's then that I know I have been infected. It's the time when I know I need to close off the source of that infection and seek out the space of supervision or peer support. I imagine that I am taking a risk in disclosing this, but there are times when I really struggle to keep my mouth shut. It is always at the end of one of those days when I have been overexposed to emotion.

We work in an extraordinary workspace, the therapy room, regularly exposed to and expected to remain in, an emotionally toxic environment. I reckon that it is an improbable goal to not be affected by what we see, hear and experience and somehow to not carry that out of the session. In fact, there are times when I am amazed at my ability to ground myself in the 10 minutes between client sessions and be present for my next client. If we were working in a physically toxic environment, I imagine the infection control regulators would have us walking through air locks, showering and dressing up like fire and rescue officers at a chemical spillage before we engaged our clients.

Which brings me back to my favourite infection control poster and the question: 'Who knows what?' Although I had a giggle at the thought of a 'typo', I did take it seriously. But more importantly, it underlined the need for me to remain vigilant to the gap between the tangible nature of germs and the intangible nature of emotion, the latter a metaphorical substance so potent that it can travel down a telephone line. People who do not work in our line of business pay attention to tangible risks and perhaps understandably don't understand the particular nature of risk in our profession, so we really do have to look after ourselves. We are not likely to see posters reminding us of the power of emotion, but those infection control posters have caused me to consider the insidious nature of our work and how shared knowledge, lying dormant in our minds, may have an effect on our relationships, our behaviour, our work. We can wash our hands but we can't un-hear what we have heard. We really do need to be careful out there or indeed 'who knows what' the effect might be on us.

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JOURNEY'S END

RICHARD MASON

Every month, we have an all service meeting which is held at St Ann's Hospital in Haringey. To get there, I take the Docklands Light Railway (DLR), a short walk from my comfortable East End pad in a reasonably affluent area; then the 'Tube' from Bank Underground station to the busy hub of Liverpool Street, where I emerge from the depths to catch the 'Overground' to Seven Sisters in Tottenham. I then walk for about 15 minutes to St Ann's Hospital.

From journey's start to finish, the streets and station platforms are like tributary streams carrying commuters towards The City. This is what it is like in my world, a humdrum hike to work during which rattling along on the DLR becomes some dreamy water-based analogy. As the trains clatter along, each stop plays out a scene. On the approach, a metallic voice announces our imminent arrival, a frisson of interest shows on the faces around the door, the train stops, the doors whoosh open, and the tide of commuters ebb out onto the platform, momentarily relieving the crush. Then a new wave flows into the carriage and I am surrounded by smartly dressed professionals, all immersed in their own worlds; many reading books, tablets, the Metro newspaper or listening to music through buzzing and beating headphones, determinedly shrinking their five senses to the absolute minimum required to interact with their fellow humanity.

My walk from Seven Sisters Station to St Ann's Hospital takes me along the Seven Sisters Road and it is here that the dreamy analogy ends. Every time I exit the station, I walk past rows and groups of hardened looking men from a variety of ethnicities and a broad spectrum of ages. They stand around in clumps, sucking hungrily on cigarettes, eating takeaway food from the local café, and some even drinking from cans of foreign branded lager. Although not dressed in worker's clothing, these men are only really recognisable as workers because of the amount of paint, plaster dust and woodchip that clings to them. They are, of course, economic migrants, men who have travelled from far and wide to hang around in this street each morning, rain or shine, to get a poorly paid day's labour in London.

Recently, as I walked through what appeared to me as a living montage of hope and desperation, I got to thinking about the lives that are behind those faces: the homes, families and friends they have left behind. I look at these men, their deportment, the group demeanour, and just know that whatever circumstances they left behind, they are not in a metropolitan paradise; they look to me to be depressed and anxious. I watched the local people walking past and through them, shrinking their five senses to the absolute minimum required to navigate the 100 yards in which they exist – these guys are invisible, right in your face, but easily blanked out. I wondered whether, in reality, they are hard to reach.

At Haringey IAPT, we put a lot of effort into considering ways in which we can identify and attract hard to reach populations; it forms a notable element of our practice. The problem with attracting men like these into treatment for common mental health problems is not so much what we offer. Our services are available through self-referral, and we have multilingual therapists, interpreter services, and documentation in the common foreign languages of Haringey. The problem is that these men are struggling to put food into their mouths whilst sending money to their families back home. In Maslow terms, they are not on a hierarchy of needs, but a 'lower-archy' of needs. You don't see these guys coming through IAPT; they really are outside of our communities, by choice or otherwise.

I travel too, from Cheshire to London each week, because London is also where the work is for me, and so I have an insight into the tensions of working away from home, though from a very different perspective. I wonder whether I would travel to Warsaw, Istanbul or Vilnius and hang around a street corner with a bunch of Western European counsellors waiting for the local service providers to turn up in minibuses and offer me a day's bank work; I wonder where I would live and how I would hold it together. I really am blessed: I have that nice apartment, I travel on well-run, well-kept trains, I eat well, I dress well, my family and friends are safe and secure, and if all goes belly up, I have the safety net of the welfare state. There is a great disparity between my definition of economic migrancy and the circumstances of these men in St Ann's Road.

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SEND THREE AND FOURPENCE, WE ARE GOING TO A DANCE!

RICHARD MASON

In British military folklore, there is a humorous tale of miscommunication, allegedly passed down to battalion headquarters by soldiers occupying a frontline trench. In the story, a frontline officer dictates the unwritten request: 'Send reinforcements, we are going to advance.' A runner then repeats the message to another runner and so on, until the final runner delivers the request: 'Send three and fourpence, we are going to a dance.' I offer this story to illustrate the importance of accurate communications. Even when working in one's own language, there is always the possibility of being misunderstood because of a difference in our world views and a perception or interpretation of what is being said.

Over the last five years, I have worked at primary care level in areas that reflect a broad range of cultures and ethnicities. Currently, one in three of my clients have requested an interpreter. I am quite experienced with interpreter work and would have thought that, after so much exposure to the dynamics of such work, I would no longer harbour the ambivalence, even avoidance, which I experience in respect of providing a therapeutic experience for clients who do not speak English. The fact is, I still find it much harder and less enjoyable than working in English on a one-to-one basis. I still think that the client does not get as good a service from me and I don't like feeling that way. I am not alone in this: many have highlighted the phenomenon, among them Tribe[1], who discusses a broad range of reasons for it but does not highlight what I think is the most important point with regards to working through interpreters: the lack of appropriately trained and experienced interpreters in the current primary care mental health environment.

Over the last few years, I have relied upon finding 'good' interpreters and sticking with them, often coaching them along the way. The majority of interpreters I have worked with have not been formally trained, and, almost exclusively, have not been formally trained in interpreting for mental health work. In that regard, I have to ask: how good is that for me? How good is that for the client? How much more pressure is that on the interpreter? Training of interpreters for mental health work is an area which I believe is neglected. These professionals are often poorly paid and given little or no incentive to invest in their profession. Agencies seem to provide services on the basis of language alone and, in that regard, an interpreter can move between a variety of assignments such as immigration interviews, general medical appointments, and primary and secondary care mental health sessions. In addition, some interpreters may not share our sense of ethics or morality.

The consequences of employing interpreters who are inadequately trained and have little incentive to invest in themselves or their continuous professional development can only add to the demands on the counsellor. Who else will monitor and ensure ethical behaviour? Who else will decide on the standard and quality of delivery? Who else will protect the rights and needs of the client in the relationship?

Working through interpreters is a real challenge for all the people in the triad. There are two languages, three world views, and three personal motivational factors to be taken into account and accommodated. There are also conflicting and converging organisational and environmental factors and much more to consider before progress can be made. It can be incredibly demanding for the counsellor. So I say: 'Send reinforcements, we are going to advance', and hopefully somebody with the power and authority to make it happen will consider resourcing and funding a national training programme for interpreters working in mental health. Only then can I focus my knowledge, skill and commitment on the needs of the client, safe in the knowledge that my fellow professional is also working to a common and informed standard of service. I am not holding my breath, but if this was the case, I rather think that in the next payslip I may find an extra three and fourpence. Anyone fancy a dance?

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A WINTER'S TALE

RICHARD MASON

Earlier this year, I dealt with a client in crisis. In IAPT services, there is a common process of referral and screening. In the three IAPT services I have worked in, this culminates in a telephone assessment. Telephone assessments can be difficult assignments; only 30 minutes to introduce yourself, clarify who you are speaking to, and then outline confidentiality, service policy, complete at least five psychometric questionnaires, obtain some narrative description of the person's presenting problem, and discuss possible treatment approaches.

This is a tall order, even with the most 'collaborative' client. Our agenda in these calls is often not aligned; I regularly find that by the time we speak, clients are desperate to share their distress, and for a compassionate listening ear and some guidance on how to manage. All these objectives are tagged onto the tasks outlined above as the clock ticks away, making it difficult to fulfil expectations without the application of tight boundaries.

One step within the assessment which cannot be the subject of a shortcut is question number 9 on the Patient Health Questionnaire (PHQ9), a questionnaire that, as a whole, deals with depressive symptoms. Question number 9 is about whether the client has any thoughts of suicide or self-harm. I have yet to speak to a colleague who does not breathe an inward sigh of relief when the reply is 'not at all'.

In my recent experience, we did not get so far. There were complicating factors which I will not share in this column, suffice to say that an intent to commit suicide was disclosed and it was a difficult session. It reminded me of the worst case scenario presented to candidates at an employment interview: 'You find yourself conducting a telephone screening late in the working day, everyone is packing up to go home and...' Two of my colleagues had picked up on what was happening, and both stayed around to ensure I was supported and not left alone. You can't buy good people. I worked hard to encourage consensus, to engage the client in the process, to instil hope in recovery from crisis and in future engagement in a therapeutic recovery. By the end of our telephone call, help was on the way.

Time is a challenging concept. I often wonder whether it really exists, whether it is really just a human construct forced upon our ancestors by ancient employers fulfilling a need to measure the value of their workers. For me, time can pass so quickly when it is my own and yet so slowly when I loan it out to others. On this occasion, the latter proved true and the effect of any cortisol and adrenalin boosts had long diminished by the time the phone call ended. I was left sitting at my desk with the Vietnam veteran's 'Thousand yard stare'. I went home that evening in a deeply reflective mood.

The following morning, I awoke with thoughts of the paperwork and documentation that would need to be completed. As I stood outside my garage, car keys in hand, I sniffed the morning air and sensed spring. It was a crisp, bright morning, so I wandered around my garden and noted that our 11-year-old Acer tree was just opening its little buds after a hard winter. I welcomed it back to life by tickling its tiny leaves. I noticed that the espaliered apple tree we planted last year was bursting into life too; I would have to think about when to tie the new shoots to the frame. By now, I was grinning with joy. The cherry tree I had planted as the last of the snow had melted away was well ahead of both the other trees, the grass needed its first cut of the year, and the blasted weeds had started to pop up in my vegetable box. I felt good, leapt into my car and set off for work, deep in thought again, reflecting on hardship, on winter, on rebirth and regrowth.

A few months later, and we are heading once again into winter. I think it is in the nature of things that we have to experience hardship – hard winters – to benefit from the spring growth that follows. That day in spring, I had dealt with a person who was in the depths of winter. My intervention may not have been appreciated; the protective cloche of the emergency services may have been perceived as a punishment. I truly hope that, in time, the thaw will set in, the snow melt, frost retract and that the person will wake up one morning to sniff the air, sense that spring has arrived and step out into a crisp bright future. I have to hope for that; it is one of the factors that keeps me in this work.

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NO DATA AVAILABLE

RICHARD MASON

Many years ago, I received a Christmas card from a client, and enclosed within the card was a photograph of a snowman. It was not a snowman of any great artistic merit; in fact, it was a very ordinary snowman in a very ordinary setting, sporting a very ordinary Trilby hat. The hat sat above two pieces of coal for eyes and a carrot for a nose and yet, for reasons that I will not share, it brought tears of joy to my eyes. I came across this photograph recently and it still has the power to move me.

A few weeks ago, I was in front of my computer at work with two sets of client notes on the desk, a stack of files to my right and a 'to do' list in my diary. I was stressing my way through a series of data input screens prior to meeting a client. My mental egg timer had reached the moment just before the final grains in the top half slip down into the bottom section. I became aware of a conversation between two of my colleagues that was about to include me. I really didn't have the time. I picked up my diary, notepad, a couple of 'minimum data set questionnaires' and headed to my appointment, thinking back to that snowman. Those were the days when I felt I had more time to reflect on my client work. Back then, my administrative commitment could be summed up as a requirement to jot down a few notes after each session. It all seems so cosy and warm.

Primary care psychological services hold many challenges for staff. One of these is the need to ensure that the people behind those 'presenting problems' have their journey recorded in a particular format. This all comes down to data, which is recorded on varied computerised patient management systems. Invariably, once the record of people's lives becomes data it attracts analysis and it seems to me that, across industries, analysis is used predominantly for performance management and that there is a danger of service delivery becoming subordinate to the recording of service delivery.

The computer systems in general use do have supportive features for the practitioner and administrator, such as template letters that automatically populate client details, a record of client contacts, and clinical, case management and supervision notes. Liaison and communications with other services are all recorded securely and in a readable format. This data is also available to data analysts for the preparation of evaluation reports on referral, activity and recovery rates, response and waiting times – you name it, the system can retrieve and present it.

Such an overview can be a little daunting, but the reality is that without all of this statistical support to demonstrate need and effectiveness, the Government would not provide the level of funding to maintain delivery of primary care mental health services, IAPT or not. At the time that I received the snowman photograph, I never imagined that my future self would be working in the way that I do now; I was only barely aware of the internet, still using a typewriter, and yet to own a mobile phone. The administration, funding and delivery of counselling and psychotherapy has moved on too. Data gathering and recording has become a crucial, if at times unwelcome, aspect of my work.

I guess that prior to the formation of IAPT, the medicalisation of people's common emotional distress became politically acceptable. Perhaps, along with that political shift, the social normalisation of psychological treatments followed. When that happens and millions of pounds are budgeted to deal with this newly accepted medical issue, the need to monitor spend becomes an imperative. People who the medical profession would once have categorised as the 'worried well' and referred into a shadowland of 'tea and sympathy' can no longer be managed in this way. What is now firmly in the mental health bracket has to be diagnosed, treated and outcome-assessed.

However, there is a hidden level of activity that the industrialisation of our work can never document. Whatever the bean counters identify as quality and seek to quantify as a means of assessing outcome, we as counsellors/psychological therapists touch people's lives in a context that can never be understood or quantified through data gathering. The real record of our work is the narrative and experience of the two people in the room and the only people who can truly assess its quality are the people in the therapy room and those people who love, live, work and socialise with our clients.

I don't remember the details of the 'snowman' client I worked with all those years ago. There is no data available either from our experience or from the narrative we shared over that time together; but I do remember the significance of the snowman and the powerful moment of self-actualisation that it heralded. Neither myself or the bean counters will ever know the outcome of that work. We will never be able to assess the value of the spend against the quality of that client's life. That snowman will have melted away over time, as the data collected today will be passed over in time. But the image of that snowman, and what it represented, remains frozen and constant in my mind.

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LOOKING IN THE RIGHT DIRECTION?

RICHARD MASON

As a child, I was often perplexed when implored to 'look after the pennies and the pounds will look after themselves'. It fell into the same box of indecipherable adult wisdom as being told to take my coat off when I entered my granny's house 'because you won't feel the benefit when you go outside'. I spent years eagerly anticipating this 'benefit' after I left her house, but my expectations were always left unfulfilled.

I attended my first New Savoy Partnership[1] annual conference late last year with that same sense of childlike anticipation. I found it to be a mixed bag. Inspiring yet chastening. There was the validation of meeting colleagues from other services; the excitement of hearing from the great and the good on progress and future strategy; and the unsettling sense of doom that comes with presentations on performance data and the weariness that rolls over my spirit when demands for more are delivered.

Norman Lamb MP, Minister of State for Care and Support, gave a moving speech on mental health and the importance of the work undertaken in primary care. Geraldine Strathdee, National Clinical Director, Mental Health for NHS England, outlined her search for ideas and innovations in the development of mental health services. There were presentations on research and discussions on the findings. Just the type of things I had expected when I was enthusiastically looking forward to the experience.

Later in the event, having platformed the good news to all, we were given a presentation of the data which are dutifully collected each month. At this stage, I began to feel uncomfortable. It was all data and no direction. The message of 'Be afraid, be very afraid', was deafening. I long for a day when data are not collected and analysed punitively; when they are collected and analysed with a view to improvement as opposed to fear. It is often the case that analysts who deal with data, rather than people, crash about like a bull in an emotional china shop when presenting feedback.

There was an input from government advisors and two service users to inform conference that service user needs are not being met. It was 'as if' the audience would not know that waiting lists are incredibly long, and that service users are limited in choice of modality, place and time of treatment. Higher recovery rates, more choice, and shorter waiting lists were demanded. Conference was addressed 'as if' nobody who works in mental health had been touched by mental health issues, the message being that for 'us', mental health was our 'day job' whilst for service users, it was their life!

I don't doubt that there are improvements to be made across the board, and that money is not the only solution. Of course, with an unlimited budget for more practitioners, we could lower the waiting lists overnight, deliver any breadth of choice that could be imagined, and recovery rates could soar. The issue is that there is a balance to be had between spend, expectation and delivery, and yet, some care needs to be exercised to ensure that the practitioners are not held responsible for all of these issues. Practitioners, hounded to maintain throughput, have limited emotional and intellectual bandwidth available for reflection and innovation; it is a wonder that recovery rates are near 50 per cent, given the volume of work they manage. It makes sense to encourage rather than intimidate these people; to make them aspirational partners, as opposed to long-suffering thralls.

Let's be honest, we work from and with our own emotions, and these are just as susceptible to our environment as our clients' emotions are affected by their own. It is a shame that there is a general misapprehension that therapists are all fully functioning paragons of emotional resilience, who exist in domestic nirvana; the Kobe beef stock of humanity. It is a shame because so many of the people I have worked with have been drawn to psychological therapy as wounded healers. Many are currently carers for loved ones or struggling with their own physical and mental health issues. These people who work as therapists are inspirational folk, all too aware of the need for more choice and shorter waiting times. If we truly want to improve the delivery of primary care mental health services, then it may help to occasionally look away from the needs of the service user, and look towards the needs of the practitioners of mental health.

As I left my first New Savoy Partnership conference, I felt a little like I used to on leaving my granny's house: unfulfilled and waiting to feel the benefit. Some of that old adult wisdom came to mind – perhaps we could start looking after the therapists and the recovery figures might look after themselves.

REFERENCE

[1] www.newsavoypartnership.org/ncc/conference.htm

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THE PRICE OF EVERYTHING AND THE VALUE OF NOTHING

RICHARD MASON

It was Oscar Wilde who wrote that a cynic 'knows the price of everything and the value of nothing'[1]. I find it tempting to adopt this line as a convenient mantra for the disempowerment which chips away at my thinking when the words 'Payment by Results' are whispered. Currently, most IAPT services are allocated a block budget each financial year and have the security of predicting how that can be spent. Payment by Results (PbR) is almost upon us, meaning that security is threatened. With this reality in mind, I recently decided to stop impersonating an ostrich whenever the words 'Payment by Results' were spoken and attend a conference on the subject.

One of the speakers was a clinical lead who is a partner in a private company operating under 'Any qualified provider' (AQP)[2]. He has embraced PbR and heads a pilot service. He was sanguine about the system and gave an interesting presentation about his experience and progress. I was interested to know how he inspired his therapists to embrace the enforced challenge of entrepreneurial service delivery. If and when PbR becomes compulsory, then IAPT services will stand or fall on their numbers, not because they might be offered out to tender, but because they may not be able to pay the wages of their staff if they don't achieve those numbers. Just like any other business, if we don't earn our money, we don't survive.

During the day, we were exposed to the ideology of PbR via a breakdown of how an accountant views the business of primary care mental health. An episode of step 2, low-intensity CBT over six sessions was costed out at about £290. An episode of high-intensity, step 3 psychological therapy was costed out at about £855. A critical observation from the pilot sites was that the NICE 'dosages' were not being followed at step 3 as a result of fiscal imperatives. That is to say, clients receive up to 12 sessions of all modalities whether or not NICE recommends 16 sessions of IPT or 20 sessions of CBT. The suggestion was, that because services are being tied to a component cost rather than a modular cost, services would seek to provide the least expensive solution to the clients' distress. For those cynics amongst you, the cost of everything and value of nothing may spring to mind.

I have mixed feelings on the subject of PbR. On the one hand, it terrifies me that the NHS is becoming more and more of a business than a service. The chief executive of NHS England, Simon Stevens, recently stated that the NHS is experiencing the most sustained budgetary crunch in its 66-year history[3]. On the other hand, as a tax payer, I can see the benefit of ensuring our money is spent wisely.

A part of me is quite excited by the prospect of puzzling my way through the costs and delivery aspects of running an IAPT service. It appeals to my long-suppressed competitive nature which has, for many years, been subjugated to my caring nature. I wonder whether I can find a way to integrate the two. Perhaps then a fresh vein of personal growth may be mined to my advantage. I suppose those last thoughts sum it all up for me. I haven't mentioned the clients, I haven't considered the impact on the people that we are here for; the people we serve. Payment by Results can do that – take the focus to the cost rather than to the benefit. It can make the client less visible because completed *Patient Experience Questionnaires* (PEQs) will earn £20 towards the maximum £290 or £855 that can be claimed for each treatment episode.

Warren Buffett, the American investment entrepreneur, informs us that, 'Price is what you pay, value is what you get'[4]. In other words, it's only by putting a cost on a service that we can judge the value of it! So, perhaps from Warren Buffet's perspective, we have developed a system of care that depends on unconditional funding; a system of care that knows the value of everything and the cost of nothing. Personally, I feel like trawling NHS jobs for a position as an ostrich. ■

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[2] *www.supplyhealth.nhs.uk/aqpresourcecentre/Pages/AQPHome.aspx*

[3] *www.bbc.co.uk/news/health-26822070*

[4] *www.minterest.org/best-warren-buffett-quotes-on-investing/*

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FOCUSING ON THE DETAIL

RICHARD MASON

Scale is a fascinating concept to me. The bigger the scale, the less the detail seems to matter. Take photography, for example. I used to play around with a decent camera when I was younger, mostly outdoors stuff, all celluloid, of course, and back then I would keep rolls of film in the fridge (for some strange reason) and get really excited about seeing my prints returned from the chemist. Some of the shots would be challenging to my photographic self-esteem and others would encourage me to continue lugging my camera around the mountains and fells of the UK and French Alps. If I had a really good picture, then I would get it blown up to a larger size. But the larger the picture got, the grainier the detail in the picture became. And so it was that the greater the scale, the less focus was available on the detail. It didn't mean that it wasn't a quality picture though.

The camera I have now is digital (and there is more room in the fridge for food). These days, I can take a photograph, load it onto my home computer within minutes, and expand the picture to explore the minutiae of the frame in perfect clarity. I suppose it all comes down to capturing the data efficiently and having the processing power to explore the detail. Hold that thought for a moment.

I really enjoyed reading the article evaluating the effectiveness of counselling within Trafford Psychological Therapies service in the last issue of this journal[1]. Let me first state my position on psychological therapies: I reckon that all the competitive measuring between modalities is egotistical and partisan. However, I have been drawn into, and horrified by, my judgmental attitude within the debate over the years, so I claim no moral high ground from my current stance. I just wish we could all play nicely together and celebrate the good work we do as a whole profession. It would be in that celebration where I would see our strength as counsellors/psychological therapists – our ability to help the decision-makers realise that modality is not the be all and end all of improving people's emotional distress.

By comparison, what I observe is the division and conquering of a group of professions by a small number of luminaries (who I have yet to see putting in a shift at an IAPT site) who jealously guard their own positions through a focus on the 'strengths' of quantitative over qualitative data; who sit in the clouds like *Match of the Day* football pundits, discoursing about how we, the therapists, could be working smarter... with more focus on service users... older people... long-term conditions etc, and I feel like saying: 'Shall we take a brush out with us and sweep the streets whilst we are at it?'

The luminaries explore only the larger picture – the really good one – thereby distracting attention away from the smaller detail. It is that smaller detail which the Trafford IAPT evaluation[1] focused on and discovered that there is yet more evidence of the current picture being digital and that the small detail is not grainy when you focus in on it. It is really clear.

To my knowledge, the people who work in our service receive a good number of 'thank you' cards and letters from clients. I say that 'I believe' because I only see the cards and letters that I see. I know that some cards are not shared because the messages are considered too personal, too powerful and too intimate to share. However, the power of IAPT is in the data available to explore – quantitative and qualitative. We have the processing power but lack the inquisitiveness to explore that objectively and, damningly, do not process and explore the qualitative data that we efficiently collect. It comes in the form of thank you cards and moving letters and is often noted in the dialogue box of the *Patient Experience Questionnaire* (PEQ). Indeed, the whole of the therapeutic process is qualitative really; it's just that we then ask clients to convert their internal processing into data. That conversion is not for the clients' therapeutic benefit, but for the monitoring of the IAPT programme. I do support the monitoring of what is the biggest psychological therapy experiment in history, but I also feel that *all* the data should be explored. If we did so, we would have a quality picture and a more informed position from which to make judgments and decisions about future approaches.

To return to photography and the scale of things: it's about having the capability to capture the data efficiently and then the processing power to explore the detail. Now, if I hadn't written that myself I would have thought that it made perfect sense for mental health services. ■

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IF IT WALKS LIKE A DUCK...

RICHARD MASON

Many years ago, my daughter stunned her grandmother with a depth of knowledge far beyond her two years' experience of the world. During a trip to the lake in the local park, the proud grandparent pointed out a 'duck' to the child, who responded in a most authoritative manner, 'It's not a duck, Gran, it's a mallard!' Oh, how proud and amused I was, because I was the one who had spent the time teaching her to recognise the different types of duck that populated the lake. My mum teased me, of course, and that teasing was validated with the comment that, 'mallards or not, they are just ducks'.

Taking over the management of an IAPT service has been a learning curve for me these last nine months. While at the helm, plenty of my time has been spent struggling with the concept of IAPT. Whereas previously I would focus on the person who was sitting in front of me, now I have responsibility to ensure that the service delivers across a wide range of contractual agreements and specifications. In all honesty, the service cannot see everyone for everything without failing to meet those demands. I am, in fact, the head gatekeeper.

I have realised that I spent a long time in my previous roles labouring under the misapprehension that I was a counsellor working in a counselling service called IAPT. It's not just me who has blindsided myself; most of our referrals come from non-mental health professionals who think no further than the descriptive 'counselling'. Counselling is, in my opinion, an excellent treatment option for most common mental health ailments. Counselling can, and does, deal with complex and long-standing presentations of the common variety. Depression, anxiety, abuse, sexual dysfunction, addictions, self-esteem issues – pile them up and send them to psychological therapy services and the counsellors will sort them out. There will be growth, there will be progress. It will just take time and that is, I believe, why waiting lists, historically, grew longer and longer.

I remember with horror and embarrassment that people waited for up to 12 months. It seemed to be alright for that to happen and I cannot remember there being any great focus on reducing waiting times. There was a focus on reducing distress, and so once a client got into treatment, it was fine. Over these last nine months, I have seen how this has changed. While there is still a focus on reducing distress, there is a demand to reduce waiting times. The trouble I have is that it seems that there is a collective blind spot among GPs and associated non-mental health professionals in respect of how those waiting times and reduction in distress is being achieved.

It is being achieved because IAPT only treats eight common mental health presentations and counselling is only applied to depression. The other seven presentations of general anxiety disorder (GAD), post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), social anxiety, specific phobia, panic disorder (with or without agoraphobia) and health anxiety, are all treated with CBT. The length of treatment is laid down in the NICE guidelines and a 50 per cent recovery rate is required. So, as a manager, I spend a fair amount of time explaining to GPs and other non-mental health professionals why we cannot accept their referrals for bereavement, addiction, self-esteem problems, eating disorders – and the list goes on. It's no small task playing the gatekeeper, signposting and educating. IAPT is what it is and it is designed, resourced and funded to deal with depression and anxiety. On a park lake full of ducks, it is a mallard.

IAPT isn't the place where all the people with common mental health problems and emotional distress can or will be treated. It didn't replace counselling services, they were just removed. IAPT was designed and resourced to deal with those eight common mental health presentations, reduce the time it takes to access those resources, and ensure that at least 50 per cent 'recover'. CCGs can, and do, commission extra services such as bereavement and long-term conditions services, but it seems to be the exception, rather than the rule.

So, back to ducks and park lakes. Twenty-four years on, that two-year-old little girl is a teacher who has just completed her third university graduation ceremony and recognises, with some qualification, that I was quite right to empower her with the ability to distinguish between waterfowl on the local park lake. Reflecting on that story and my current relationship with colleagues who take the view that 'IAPT or not, it is just psychological therapies', I wonder whether I should empower them with the ability to distinguish between the metaphorical ducks on the park lake by responding, 'It's not the panacea for all mental health issues, it's an IAPT service!' ■

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HOW TO RUIN A GOOD WALK

RICHARD MASON

They say that to play golf is to ruin a good walk. I used to play a bit of golf but was never very good at it. I didn't reach that standard whereby I could feel relaxed about my efforts, or be good enough to join the ranks of the club members on account of being that person who holds other people up by losing balls, slicing shots onto another fairway, or overshooting the hole. I would be that player furiously putting backwards and forwards across the green in a desperate attempt to plop my ball into the hole. What really did it for me was the amount of times I ignominiously stood to one side to allow the group behind to 'play through'; a euphemism for being in too much of a hurry to let the person in front of you enjoy their game at their pace.

These days, the nearest I get to ruining a good walk is when I take my retired gun dog, a springer spaniel named Rhea, on her Sunday morning route. We tromp along a section of the Wirral Way, taking the bridleway rather than the footpath so that she can charge through the hedgerows in search of game to spring!

At a certain point, we hang a left and cross the golf course down to the estuary. I have to put her on the lead at this point because she loves to chase tennis balls and bring them back to me. Much to my amusement, she doesn't distinguish between big fat yellow tennis balls and skinny little white golf balls. From my perspective, the scenario of a golf ball being struck beautifully down a fairway, only to be returned moments later by a happy little, tail-wagging, springer spaniel is an amusing one. The golfers would no doubt disagree, and so I place her on the lead for that section of the walk; not because I don't trust her, but because people can get so caught up with measuring what they are doing that a springer spaniel's 'helpfulness' could be misinterpreted and attract negativity.

It's a funny thing that we measure activity in almost everything we do. I recognise that humanity has achieved so much because of that obsessive trait: how long it takes to get to work, the distance between two places, whether a person is on time or not, how many calories we should eat per day etc. I suppose it has to do with a need to control our environments. If we know 'how many', 'how long', 'what colour', 'what temperature' etc, then we can predict our futures, and the more detailed the measure, the more we can predict and the safer we feel. That prediction, that reliability, that need to value activity, can overcome the meaning of the activity itself and it is at that stage for me that the trait becomes dysfunctional.

Today, Rhea and I sat on a bench and watched the golfers follow their passion. I wondered how it would be to engage with golf for the sheer pleasure of whacking a ball and walking after it. Chatting to friends as I did so, following the course without having to count how many shots I had taken, feeling no pressure to observe the rules and measures – just enjoying the pleasure of being and doing. I reckoned that, at the end of that round, I would have had a very good walk, would feel good about myself, and would go home feeling as though I had spent my time well.

Sitting with my dog on that bench, watching the golfers, I tried to imagine what would happen if those golfers sat and watched the Wirral Way for a moment; and saw my dog furiously working her way through the hedgerow. I imagined that if the golfers applied their frame of reference to us, so that Rhea and I had measures and rules for our Sunday morning walks, then we would doubtless feel that our good walk was ruined. Not by the activity, but by the measures imposed to value what we do when we are out on our walk. So, with that in mind, I reflect upon IAPT and the level of activity-measuring that is demanded, the effect that the measures and the rules applied to the work has on some therapists working in IAPT, and how it can taint their experience of working in primary care. I reckon I have turned a corner on my view of golf now. Next time somebody tells me it is the ruin of a good walk, I will explain that it's not the golf that is responsible – it's the measurement of the activity that ruins the walk. ■

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METRIC VERSUS IMPERIAL

RICHARD MASON

Back in the early 1980s, when I changed my personal transport method from two wheels to four, I discovered that the toolkit I had built up to maintain my Japanese motorcycles did not quite fit the old British motor car that I had bought. The trouble was that my Japanese motorcycles were built to metric specifications and so had metric tools, while the British banger was held together with imperial nuts and bolts. It was millimetres versus inches. I didn't have the money to replace my metric tools, so I tried hard to make do; this took the corner edges off many a nut and bolt, not to mention my poor knuckles. It got the job done though – after a fashion. Over time, I bought the odd imperial spanner which made servicing my car much easier and less painful. My metric tools remained a resource, and I found that having both options made it easier to work with a choice of tools to match the problem I faced.

Recently, in my role as team lead, I have been bombarded with emails from recruitment agencies. They have been offering counsellors and psychological therapists who are available for work in IAPT. All of my recruitment has to go through NHS jobs, so I wouldn't be able to employ any of these people, but I read through the many CVs and was struck by the high level of qualifications and experience being offered. I was also struck by the fact that none of them had a CBT qualification. It reminded me a little of the metric/imperial toolkit struggle I had experienced as a younger man.

In our service, and in many others, the baseline qualification is a postgraduate diploma in CBT – call it a metric spanner – and for the want of that metric spanner, those people are not going to be considered for a post in IAPT. It is a crying shame.

The majority of vacancies I advertise are at what IAPT calls step 2 low-intensity. This is predominantly guided self-help interventions. It is a busy, challenging environment that is best suited to IAPT-trained Psychological Wellbeing Practitioners (PWPs). They know what is required and how to deliver this model of therapeutic intervention. They are a metric spanner for a metric nut.

I have run four recruitment campaigns for step 2 practitioners in the last 12 months and each time I make it clear that only qualified PWPs should apply. Again it is a crying shame, because the majority of applications come from people who are well qualified but lack the required PWP qualification. I have paper-sifted people with psychology degrees, counselling diplomas and master's qualifications in counselling; I even found a candidate with a PhD. My point is that there is no shortage of qualified and experienced people out there who want work. The issue is that IAPT, the biggest employer of psychological therapists in England, needs practitioners with the ability to offer CBT interventions. IAPT has a standardised approach to emotional distress.

Notwithstanding, within IAPT, there has been the introduction of more choice through models such as interpersonal psychotherapy (IPT), counselling for depression (CfD), dynamic interpersonal therapy (DIT) and couple therapy for depression (CTD); but frankly, in IAPT, we treat a prescribed list of emotional disorders with CBT, and just one on that list (depression) with the other models. The NICE guidelines favour CBT, and that ultimately decides whether people can secure paid employment in IAPT services, irrespective of their qualifications and experience. In a world where everything is measured and contracts demand strict compliance to activity and recovery rates, CBT is the most flexible and attractive option for employers. It is a metric spanner for a metric nut.

Obviously, people don't come in metric or imperial specifications, so there will never be one therapeutic model that 'fits all'. And so, the universities and colleges churn out a wide variety of courses and qualifications. These courses bring in a lot of revenue and yet, I would argue, they do not fit the needs of the students' employment aspirations or prospective employers' needs. In my opinion, it is time that the course providers had a look at the employment market and started to offer training that increased a student's prospect of employment on graduation. In time, I do not think it is too much to hope that a baseline qualification is devised which suits the NICE guidelines, guarantees patient choice beyond one approach, and gives parity to our profession with other professions such as physiotherapy.

Psychological therapy could be delivered by a person with a respected national standard qualification that enables practitioners to facilitate collaborative engagement and apply whatever interventions are best to relieve the client's distress. As we motor along further into the 21st century, would it be too much to ask that a client can walk into a room and get on with the business of recovery without having to consider what approach the practitioner offers, and leave the choice of spanners to the clinician? ■

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INSPIRED BY KIPLING

RICHARD MASON

A favourite book of mine is a tatty old copy of Rudyard Kipling's *The Jungle Book*. The characters are mainly animals, and I imagine that Kipling based them on people who were in his life at the time of writing. I like to think that, if I could be transported back in time to observe his life then, I would be able to point out the people he based the characters on.

I have resigned from my post in the NHS. I am heading off to study for a doctorate in counselling and psychotherapy at the University of Chester and I also plan to develop a private counselling and supervision practice. There was no absolute reason why I resigned. As a manager in the NHS, my role often demanded that I engage in activity that I felt was too focused on management and not enough on leadership. I had become drawn more and more towards the insatiable demand to collect and produce data, review data, check their accuracy, and account for the level of performance that the data indicated. I found that I was available less and less to spend time with the team. I found that my world was shrinking into the office space that I occupied and that I spent less time looking out of my window, reflecting on how to improve service delivery and client satisfaction, and more time staring at spreadsheets. My computer screen had become the window into my professional world and that world was shrinking.

As I stated, there was no absolute reason for my resignation; I managed all of the above and more. I learned heaps about primary care mental health provision, and I had a fair bit of fun too, mostly when the team was around and we indulged in the restorative activity of laughter.

I suppose the tipping point came when my email screen lit up with an advertisement for the doctorate at the University of Chester. I realised that it was time to pursue something different, that my relationship with the NHS had run its course, and that I was fortunate enough to be able to follow a new path.

I have worked in IAPT for seven years and have had a love-hate relationship with it throughout. I really do, however, believe that IAPT is a very good model. It is well designed and well thought through, and has the benefit of being evidence based. IAPT was designed to work with a specified number of issues which have been normalised and so fall into the comfortable framework of diagnosis. For each diagnosis there is a treatment plan, and when delivered to a population that is struggling with one of those diagnoses, it is very effective. So I say leave IAPT to itself and give credit where it is due. I also say that if IAPT is designed to deal with a specific number of issues, then where are all the other services? Services designed to deal with bereavement, anger, abuse, addiction, life transition and all the 'pick and mix' co-morbidity that occurs in humanity?

It is my belief that mental health provision is often poorly commissioned. The unacknowledged consequence of poor mental health commissioning is that too much reliance is placed on IAPT to be all things to all people. One approach, most definitely, does not fit all needs. The normative approach of distilling all of humanity's emotional struggles into an accepted 'peer reviewed' truth, while currently acceptable, should itself be reviewed; and the 'peer group' who review it should represent the broad brush of the humanity that it will serve. We should have IAPT services all over the country and they should exist as a consummate part of a range of commissioned services, designed to deal with the full gambit of emotional distress in our society. There should also be wider strategies, beyond treatment, that seek to emotionally educate people and reduce the prevalence of emotional distress before it occurs.

My intention is to study the relationship between the different approaches to dealing with people's common emotional distress. In that regard, my experience in the provision of primary care mental health will be invaluable. I am really excited about the prospect of deepening my understanding of where we are now and how we arrived here. Most people who I have spoken to about it are envious of my opportunity, although, like me, they are unsure of where it will lead to – and that is what I find most exciting about my change of direction.

So, as I prepared to sign out of my NHS job, I thought about Rudyard Kipling and *The Jungle Book*. I reflected fondly, and with not a little sadness, on the characters in the team that I am leaving. I looked up at the wall and my whiteboard, which has the names of the team on it, and thought about which of Kipling's characters best fitted the people in the team.

This will be my last column for this journal, as I don't think I can represent counsellors and psychotherapists in primary care when I am no longer serving. Thank you for reading this column, thank you for all the feedback you have given me, and good luck for your futures. ■

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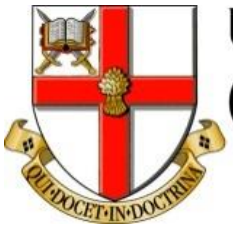
Appendix. 2 – Extract of Coded Transcript

Time code	Speaker	Transcript	Analytical Memos
	INEQUALITY IMPEDED	They offered CBT training out to the company, so companywide, but the only people who were accepted for CBT training were PWPs.	
00:09:13	S1	Oh, okay, I see. So, what stopped you from not taking the CBT training?	
00:09:20	S2 IMPEDED SECTARIANISM INEQUITY IDEOLOGY	I applied and was turned down. I was told that my modality, my background wasn't conducive to then going on to CBT training.	Counsellors employed on a psychological contract that ECfD and DiT were to be available, then refused CBT training because she was a counsellor
00:09:34	S1	Okay, so you applied for the CBT training, but they refused it to you.	
00:09:41	S2 GENERIC	Yeah.	
00:09:43	S1	So, what happened after that? From your perspective, how did that leave you?	
00:09:51	S2 BELIEF-SELF-NEGATIVE DISENGAGED BULLYING IMPEDED SECTARIANISM	[after being refused CBT training I felt] Marginalised, I felt very de-skilled. There was a clinical psychologist who ran the organisation and she was very bullying. And if you are not a CBT therapist, then there was no way you	Pretty powerful stuff, being deliberately blocked from PD, and after being recruited with the promise of PD, this is an example of how counsellors can be flexible and want the CBT training, but favour is show to others.

Time code	Speaker	Transcript	Analytical Memos
		are actually going to be able to move forward or get any training.	

Appendix. 3 – Participant Consent Form



University of Chester

Consent Form

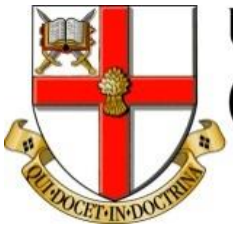
"What are the professional development implications for Counsellors who have worked in the English Improving Access to Psychological Therapies (IAPT) programme?"

Name of Researcher: Richard Mason — Please initial box

1. I have read and understood the participant information sheet and have had the chance to ask questions. ☐
2. I agree to the research conversation being audio recorded. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time prior to the commencement of writing up the stage 1 findings, and the associated development of the survey instrument. At which stage, I will be contacted to clarify consent. ☐
4. I agree to take part in this study. ☐
5. I understand that the data will be written up as part of a thesis and I will not be identifiable in the thesis. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Appendix. 4 – Participant Information Sheet



University of Chester

Participant Information Sheet

"An exploration of professional development implications for Counsellors who have worked in the English Improving Access to Psychological Therapies (IAPT) programme?"

Dear

Thank you for indicating that you are interested in taking part in this research. You have been invited to take part in Phase 1 of the study because you are a counsellor who has worked in IAPT, and since left. This Information Sheet will hopefully explain what is involved, but if you need further clarification, then please do not hesitate to contact me using the contact details below.

What is the purpose of the study?

This research is part of a Professional Doctorate in Counselling and Psychotherapy Studies / Psychological Trauma that I am undertaking at the University of Chester. I would be interested in exploring your views on, and experience of IAPT from a professional development perspective. My interest includes pre-IAPT, working in IAPT, and post-IAPT perspectives.

What will happen to me if I take part in Phase1 of the study?

To enable this, if you decide to take part, I will arrange a time to interview you face-to-face at your convenience, or to have a SKYPE interview with you if that is more convenient. Your written consent will be obtained through the enclosed consent form (which you can post or scan and email to me if the interview is conducted through SKYPE/FaceTime). The interview will be digitally recorded and last no more than an hour.

The interview will be semi-structured and be focussed around the following questions:

Joining IAPT

- What factors influenced your decision to work in IAPT?

- On being recruited to IAPT, to what extent, if any, might the following factors from Maslow's Theory of Human Motivation (Maslow,1943) been evident in terms of your needs: Physiological needs; Safety; Love/Belonging; Esteem; Self Actualisation?

Working in IAPT

- What professional development opportunities were available to counsellors in IAPT?
- What professional development opportunities were available to you in IAPT?
- If there is a difference between the last two questions; what do you attribute that difference to?
- What professional development opportunities did you avail yourself of in IAPT and why?
- To what extent, and how, has IAPT changed or influenced your clinical practice?

Leaving IAPT

- What factors influenced your decision to leave IAPT?
- Having left IAPT, do you have any regrets about leaving, and why?
- If you were re-joining IAPT, on reflection, how would your experiences guide your approach to professional development?

Once the interview is complete, the digital recording will be transcribed. Your transcript will be allocated a pseudonym or code to protect your anonymity, and any identifying features in the data will be deleted. The transcript will be emailed to you to check for accuracy and to give you an opportunity to amend or change any of the data.

Your right to withdraw without prejudice

You have every right to withdraw from the research at any time, without prejudice, up until the point that the stage one (qualitative) findings have begun to be written up. I will let you know when that is, and seek your continued approval. Once the writing-up has begun, it will be impossible to remove your data as it will be aggregated, making your data more difficult to identify.

What are the possible disadvantages and risks of taking part?

I cannot foresee any disadvantages or risks to taking part, except the cost of your time. If, for any reason, personal issues are stirred for you, I am an experienced therapist, so I will do my best to support you in the time we are together. I am also able to furnish you with a list of therapists in your locality whom you may be able to access. In accordance with the University of Chester Research Governance Handbook (2014) in the unlikely event "that a participant is harmed by taking part in the research, there are no special compensation arrangements"

What are the possible benefits of taking part?

The experience will give you time to reflect on your work, and to share your thoughts. This may contribute to something greater at research and policy level.

What if something goes wrong?

I will do everything within my ability to ensure your safety and confidentiality. However, if you are not happy with any aspect of the research process, please raise it with me. If you are still not happy, you may raise it with my Research Supervisor, Dr Andrew Reeves, at the University of Chester: (https://www.chester.ac.uk/sps/staff/dr-a-reeves)

If you are still unhappy with things, you may then raise it with the Dean of Faculty, Professor David Balsamo: Email: d.balsamo@chester.ac.uk

Will my taking part in the study be kept confidential, and how will my data be stored?

The fact that you are taking part in the research, and everything that you share, will remain confidential. In the unlikely event that Child Protection issues are raised, I may have to alert Social Services or Police, but otherwise, what you share will form part of the data which will be anonymised by use of a pseudonym or code. The data will be stored securely in locked premises and kept encrypted on a password protected computer. Only I, and my Research Supervisor, will have access to the data. The data will be destroyed (shredded or electronically deleted) after five years, in keeping with the data protection act.

What will happen to me if I take part in Phase 2 of the study?

Phase 2 of the study will entail logging onto a web-based survey instrument (Bristol Online Surveys) which is similar to commercial models such as survey monkey and completing a tick box questionnaire. The questionnaire will seek to gather the strength of your opinion on statements that reflect themes which have emerged from Phase1 of the study. As an example, a question such as “During my time working as a Counsellor in IAPT, I felt as valued as my colleagues who practised manualised therapies i.e. CBT, IPT, EMDR” you would be asked to select a response from choices ‘strongly agree’ ‘agree’ ‘neither agree or disagree’ ‘disagree’ ‘strongly disagree’. This is often referred to as a Likert Scale Questionnaire and will be used to test the findings of Phase 1 across a larger population of counsellors who have also worked in IAPT and since left. Upon completing the questionnaire, it will not be possible for your responses to be removed from the survey, and therefore you will have no right of withdrawal from the study. The questionnaire will be anonymous.

What will happen to the results of the research study?

The completed research will be stored (bound and electronic) at the University of Chester. The research will be disseminated in future publications and at conferences.

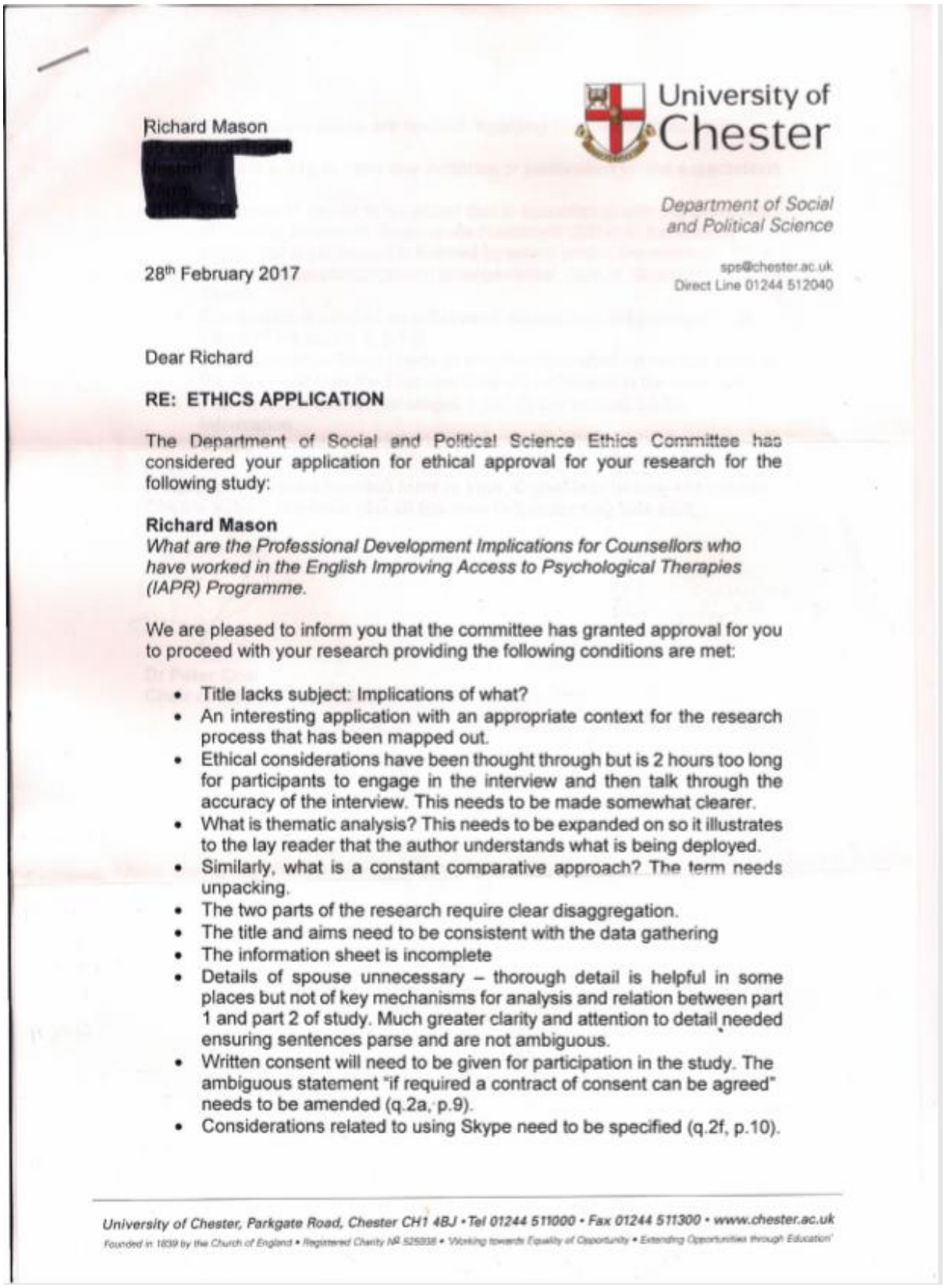
Whom may I contact for further information?

I, the researcher, am: Richard Mason

My contact details are: mason.r@chester.ac.uk

Thank you for your interest in this research.

Appendix. 5 – Ethical Approval



Richard Mason
[redacted]

University of Chester

Department of Social and Political Science

sps@chester.ac.uk
Direct Line 01244 512040

28th February 2017

Dear Richard

RE: ETHICS APPLICATION

The Department of Social and Political Science Ethics Committee has considered your application for ethical approval for your research for the following study:

Richard Mason
What are the Professional Development Implications for Counsellors who have worked in the English Improving Access to Psychological Therapies (IAPR) Programme.

We are pleased to inform you that the committee has granted approval for you to proceed with your research providing the following conditions are met:

- Title lacks subject: Implications of what?
- An interesting application with an appropriate context for the research process that has been mapped out.
- Ethical considerations have been thought through but is 2 hours too long for participants to engage in the interview and then talk through the accuracy of the interview. This needs to be made somewhat clearer.
- What is thematic analysis? This needs to be expanded on so it illustrates to the lay reader that the author understands what is being deployed.
- Similarly, what is a constant comparative approach? The term needs unpacking.
- The two parts of the research require clear disaggregation.
- The title and aims need to be consistent with the data gathering
- The information sheet is incomplete
- Details of spouse unnecessary – thorough detail is helpful in some places but not of key mechanisms for analysis and relation between part 1 and part 2 of study. Much greater clarity and attention to detail needed ensuring sentences parse and are not ambiguous.
- Written consent will need to be given for participation in the study. The ambiguous statement "if required a contract of consent can be agreed" needs to be amended (q.2a, p.9).
- Considerations related to using Skype need to be specified (q.2f, p.10).

- More specific details are needed regarding how participants will be recruited –
  (q.3a ii, p.11). Is there any evidence or justification for the expectations stated?
- A statement needs to be added that in accordance with the University of Chester Research Governance Handbook (2014) in the unlikely event "that a participant is harmed by taking part in the research, there are no special compensation arrangements" (q.4, p.15 and Information Sheet)
- Clarification is needed on withdrawal procedures for participants in Part II of the stud(q.8, p.13)
- The Information Sheet needs to provide information on the two parts of the study and how the interview data will be utilized in the research.
- The inclusion criteria (for stages 1 and 2) are needed on the Information
  Sheet.

Please return your amended form to your Supervisor in order to receive Chair's action. We wish you all the best in conducting this study.

Yours sincerely

Dr Peter Cox
Chair of Ethics Committee

Richard Mason
[redacted]

3rd April 2017

Dear Richard

RE: ETHICS APPLICATION

Thank you for submitting your amendments to your ethics application for the following study:

"An exploration of professional development implications for Counsellors who have worked in the English Improving Access to Psychological Therapies (IAPT) programme?"

We are pleased to inform you that the required amendments have been satisfactorily completed. Ethical approval has now been granted for you by Chair's action. You may now proceed with your research, subject to appropriate consultation with your supervisor.

We wish you all the best in conducting this study.

Yours sincerely

Dr Peter Cox
Chair of Ethics Committee

Appendix 6 Code Frequency Tables Across Participants - Themes 1/2/3

Each table presents a column demonstrating the prevalence or frequency of each code relative to each participant interview. In essence the number of times each participant used narrative that was reflective of a particular (coded) meaning. The final column represents the number of times that each code was observed across all of the participant interviews contributing to the creation of that theme. I have then presented each code in context, exemplifying them with narrative extracts from the participant interviews. It is hoped that this method will assist the reader in understanding the contribution of the codes in developing the themes, along with an element of transparency. Greater detail on the definition of each code can be obtained by reference to the code book.

Theme 1.

Code	P02	P03	P04	P06	P09	P10	P15	P16	Prevalence
Business	10	24	08	30	13	11	10	01	107
Bullying	03	01	03	05	Nil	Nil	Nil	04	16
Development-Impeded	05	21	09	20	08	05	09	10	87
Development-Facilitated-Formal	05	25	14	Nil	Nil	14	01	02	60
Development-Facilitated-Informal	17	18	03	04	14	04	04	04	68
Ethical	02	03	04	05	16	01	01	07	39
Exploitation	10	01	Nil	06	06	Nil	Nil	Nil	23
Health	01	01	16	Nil	Nil	02	Nil	02	22
Inequity	06	03	04	06	10	03	Nil	Nil	32
Management	12	11	23	09	07	12	06	08	88
Psychological Contracting	07	13	02	04	09	Nil	Nil	01	36
Sectarianism	03	11	10	07	Nil	02	03	04	39
Supervision	06	03	01	04	03	04	01	02	24
Tolerance	15	11	11	14	15	07	07	Nil	74
Tolerance-Intolerance	07	01	05	03	04	05	02	10	37
Workload	11	07	02	05	07	05	02	Nil	39

Theme 2.

Code	P02	P03	P04	P06	P09	P10	P15	P16	Prevalence
Censure-Counsellors	01	01	Nil	Nil	Nil	Nil	Nil	Nil	02
Censure-Self	01	01	05	05	01	02	Nil	01	16
Development-Impeded	05	21	09	12	09	05	07	10	73
Development-Facilitated-Informal	37	18	03	05	16	04	06	Nil	89
Employability	34	15	14	06	09	08	01	04	91
Equality/Inequity	12	24	05	06	10	03	02	02	64
Ethical	02	03	05	05	15	01	01	07	39
Exploitation	07	05	Nil	06	06	01	Nil	Nil	24
Growth	20	11	02	04	05	05	Nil	02	49
Ideology-Difference	18	18	09	15	22	10	23	14	124
Ideology-Idiographic	01	10	26	03	01	14	02	08	65
Ideology-Nomothetic	01	Nil	01	01	01	03	Nil	Nil	07
Ideology-Pluralistic	18	24	05	Nil	08	02	01	Nil	58
Informatics	03	11	05	05	04	10	05	05	48
Manualised	03	08	12	08	02	08	02	02	45
Supervision	06	03	01	04	03	05	03	Nil	25
Treatment	18	16	17	04	10	16	06	03	90

Theme 3.

Agency-Active	21	06	04	07	07	10	01	06	62
Agency-Passive	Nil	06	12	02	09	05	01	Nil	35
Belief-Self-Negative	11	03	15	30	09	02	Nil	Nil	70
Belief-Self-Positive	16	10	10	03	03	04	Nil	Nil	46
Belief-Self-Unsure	Nil	04	02	01	04	04	Nil	Nil	15
Change-Pre-Contemplative	04	03	09	04	03	02	11	06	43
Change-Contemplative	11	04	10	08	13	06	08	05	65
Change-Preparation	04	01	01	01	03	01	Nil	03	14
Change-Action	10	12	09	12	05	13	01	03	64
Change-Maintenance	06	05	05	02	02	03	Nil	02	25
Drivers-Ambiversion	02	14	01	02	03	Nil	Nil	01	22
Drivers-Extroversion	01	01	04	02	02	Nil	Nil	01	10
Drivers-Introversion	02	03	12	08	10	18	04	05	64
Engaged-Acceptance	Nil	01	Nil	Nil	Nil	10	Nil	03	11
Engaged-Disengaged-Rejection	03	14	16	17	15	05	07	07	70
Frustration-Aggression	05	04	10	01	03	16	10	06	56
Frustration-Fixation	01	03	09	01	04	02	12	03	35
Frustration-Regression	Nil	02	07	01	Nil	03	05	01	18
Frustration-Resignation	06	03	05	10	13	02	01	02	42
Growth	20	11	14	07	07	09	Nil	03	71
Reflexivity	01	13	08	03	10	05	03	04	47
Leaving	06	06	15	18	13	09	02	06	85

Appendix. 7 – Codebook

The following pages present the codebook used during the analysis stages of this research. In this process a *Theme* is defined to be an overarching unit of meaning , observed by the analyst that is presented in the data or text. A *Code* is a narrative description of elements of the data that contribute to that theme, thereby becoming a component of the theme. The codebook is a narrative compendium of codes, which includes description of how that code relates to the other codes (Guest, Namey & MacQueen, 2012, p.50).

Code	Brief Definition	Full Definition	When to Use	When not to Use	Example
ADVANTAGE	Counsellor being treated advantageously	Counsellors in IAPT are often treated differently to other mental health practitioners, whilst being expected to undertake the same workload, case load, level of severity, and complexity of presentations. Counsellors generally work within IAPT at 'High Intensity – Step 3' yet are often graded and paid less than other high intensity practitioners. However, this is not always true depending on local circumstances, and counsellors may be treated advantageously in comparison to their manualised colleagues.	Apply this code to all references to counsellors experiencing advantageous status and/or conditions in comparison to their manualised colleagues, irrespective of their status as counsellors, ideological, or ethical stance, approach to treatment, or qualifications.	Do not use this code when the data indicates that counsellors have been treated with inequality, or equality in comparison with manualised colleagues.	"They allowed me to have my own little room at one point ... [we got] some budget and we were able to put up some lime green blinds and a nice lime green picture of like a big tree and put a couple of comfy chairs in there. So, it was like a proper therapy room. Whereas the others all worked at desks with laptops. Little, little, really tiny old rooms with laptops and desks, you know?"

AGENCY-ACTIVE	Counsellors taking control of professional development	There are examples during narrative of counsellors describing passive attitudes and behaviours towards their professional development. Agency is the capacity of an actor to act in a given environment. In this study, an agent can be described as a counsellor engaging with the social structure i.e. the IAPT programme and its professional development opportunities and structures. The level of reflexivity a counsellor may possess, or communicate may be relevant to this code, as decisions to engage and therefore taking agency may rely upon the counsellor valuing his/her professional development, recognising and making decisions on what IAPT has to offer, and what they may engage with, but a key aspect will be reflexivity.	Use this code when counsellors take an active role in decision making about CPD or opportunities regarding professional development. This may relate to accepting training opportunities or declining for professional or personal reasons.	Do not use this code when data suggests that the counsellor has not demonstrated reflexivity in decision making relating to professional development	"at one point I was offered … PWP training, but again, I saw that as a retrograde step"

AGENCY-PASSIVE	Counsellors not taking control of professional development	There are examples during narrative of counsellors describing passive attitudes and behaviours towards their professional development. Agency is the capacity of an actor to act in a given environment. In this study, an agent can be described as a counsellor engaging with the social structure i.e. the IAPT programme and its professional development opportunities and structures. These may include formal and informal opportunities, such as professional courses with qualifications, or reflexive learning from activity. The level of reflexivity a counsellor may possess, or communicate may be relevant to this code, as decisions to engage and therefore taking agency may rely upon the counsellor valuing his/her professional development, recognising and making decisions on what IAPT has to offer, and what they may engage with. Agency will include counsellors making decisions to not engage, as well as engaging, but a key aspect will be reflexivity.	Use this code when data suggests that counsellors are not engaging with IAPT as an opportunity to progress professional development and waiting for opportunities to be offered or provided by the service. such examples might be counsellors bemoaning the lack of opportunity whilst manualised therapists are being offered training. counsellors may communicate as being disempowered	Do not use this code when data suggests that the counsellor has demonstrated reflexivity in decision making in relation to professional development	

			around professional development.		
BELIEF-SELF-NEGATIVE	Counsellor negative self-belief	The concept of internal evaluation and external evaluation is a key aspect of Rogerian theory. During counsellor training there is a considerable element of time and resource devoted to personal growth, and the development of a strong internal evaluation capacity. Counsellors, as a result, learn to rely on this aspect of self-management in relation to their work [and also private lives] as a guide to maintaining elements of the Rogerian core conditions of Respect, Congruence, and Empathy. in theory, always challenging the internal evaluator, is the concept of external evaluators, a balance needs to be found and maintained in what is a dynamic commitment to self. the self being a core aspect of the counselling process, within the therapeutic	Use this code when data suggest that the participant has disclosed a negative effect on their self-belief (both professional and personal) as a direct result of IAPT working experience. Include feeling de-skilled. This	Do not use this code for comments which suggest that the negative contribution to the counsellors self-belief are non-IAPT attributable i.e. in the case of censure for having worked in IAPT	'... everything else around it [IAPT] became nightmarish, all the meetings, and all the pressure, and all the constant, kind of, you know, "You're not right, this isn't working because it's not that" And all of that, it just

		relationship. in IAPT the strong, and often overpowering, external evaluators created by measures, such as manualised approaches, NICE guidelines, contractual demands, programmatical procedures and policy can and will have an affect counsellors self-belief.	may include post IAPT work attributable to IAPT work experience.		became horrendous over time, it built up, and up, and up'
BELIEF-SELF-POSITIVE	Counsellor positive self-belief	The concept of internal evaluation and external evaluation is a key aspect of Rogerian theory. During counsellor training there is a considerable element of time and resource devoted to personal growth, and the development of a strong internal evaluation capacity. Counsellors, as a result, learn to rely on this aspect of self-management in relation to their work [and also private lives] as a guide to maintaining elements of the Rogerian core conditions of Respect, Congruence, and Empathy. in theory, always challenging the internal evaluator, is the concept of external evaluators, a balance needs to be found and maintained in what is a dynamic commitment to self. the self being a core aspect of the counselling process, within the therapeutic relationship. in IAPT the strong, and often	Use this code when data suggest that the participant has disclosed a positive effect on their self-belief as a direct result of IAPT working experience. Include feeling up-skilled. This would include post-IAPT work experience	Do not use this code for comments which suggest that the positive contribution to the counsellors self-belief are non-IAPT attributable i.e. in the case of external counselling work.	'I really got a sense of becoming a better practitioner, more knowledgeable, more experienced about wider aspects of mental health work'

		overpowering, external evaluators created by measures, such as manualised approaches, NICE guidelines, contractual demands, programmatical procedures and policy can and will have an affect counsellors self-belief.	were the counsellor has drawn on IAPT attributed growth or learning.		
BELIEF-SELF-UNSURE	counsellor unsure of self-belief	The concept of internal evaluation and external evaluation is a key aspect of Rogerian theory. During counsellor training there is a considerable element of time and resource devoted to personal growth, and the development of a strong internal evaluation capacity. Counsellors, as a result, learn to rely on this aspect of self-management in relation to their work [and also private lives] as a guide to maintaining elements of the Rogerian core conditions of Respect, Congruence, and Empathy. in theory, always challenging the internal evaluator, is the concept of external evaluators, a balance needs to be found and maintained in what is a dynamic commitment to self. the self being a core aspect of the counselling process, within the therapeutic relationship. in IAPT the strong, and often	Use this code when data suggest that the participant has disclosed feeling unsure in respect of their self-belief as a direct result of IAPT working experience. This may include post IAPT work attributable to	Do not use this code for comments which suggest that contribution to the counsellors uncertainty regards self-belief are non-IAPT attributable i.e. in the case of censure for having worked in IAPT	"whether I met the service's needs I've got no idea".

		overpowering, external evaluators created by measures, such as manualised approaches, NICE guidelines, contractual demands, programmatical procedures and policy can and will have an affect counsellors self-belief.	IAPT work experience.		
BULLYING	Counsellors being bullied	Counsellors will often relate experiences whereby the relationship between themselves and others [management, peers, clients, CCG, GP's and other NHS workers] is indicative of being bullied. This is not always explicit and at times the counsellor will not recognise this in their relationships. as a guide the GOV.UK definition is 'Bullying and harassment is behaviour that makes someone feel intimidated or offended.'	Use this code for examples of text where counsellors express relationships which could indicate that they were feeling intimidated or offended.	Do not use this code if the data is not clear on this issue, or if the counsellor is the person demonstrating examples of being the bully.	my manager made a comment. She was an ex nurse and she was…well, we won't go into personality…but she was a bit of a slave driver

BUSINESS	IAPT as a Business Model	IAPT as seen through the lens of a business model. There is no published business modelling for IAPT. The IAPT implementation plan (2008) has been individually interpreted by each NHS or Other Qualified User contract holders. These individual interpretations of how to deliver the IAPT programme vary significantly. Contract holders will inconsistently employ a variety of localised methods, policies, and procedures at an analytical, managerial, and Human Resource level to meet HSCIC data collection requirements, and NHS England service delivery standards.	Apply this code to all references to managerial, and contractual practice; managerial decision making [rather than clinical]; general running of IAPT services from a business perspective. Counsellors professional development will be affected by managerial behaviours and practices, and this code is intended to capture those examples. This code may be considered for dual use if there are cross	Do not use this code for references to clinical decision making, Counsellor decision making in respect of counsellor professional development [unless influenced by managerial decision making]	"it also made me cross that I couldn't get paid work, having worked really hard for 18 months, nearly two years with them; unpaid working with step three patients who can be really quite poorly"

			over implications with the treatment code.		
CENSURE-COUNSELLORS	Counsellors feeling disloyal	There appears to be a sense of groupthink amongst counsellors, and within the counselling profession that IAPT is the enemy. Counsellors can feel that they are being disloyal if they positively appraise aspects of IAPT or enter into IAPT provided CPD. there is a general sense that counsellors will be censured by colleagues if they conform.	Use this code when participants reference any sense of feeling guilt, being chided, feel negatively judged etc. for their association with IAPT, or for conforming to IAPT business or	Do not use this code in cases where the counsellor expresses confidence in their positive decisions, behaviours or opinions in relation to IAPT, such as accepting and conforming to IAPT training	I was thrilled to be offered IPT training, it was just what I wanted and needed to do my job'

			treatment requirements. Or if counsellors do not engage or conform for fear of negative judgement.	willingly and happily.	
CENSURE-SELF	Counsellors self-censure	Counsellors are encouraged through training, and practice to engage in self-reflective practices. It is considered to be virtuous and practically essential to counselling practice to self-reflect particularly in relation to values, behaviours and beliefs. The process engaged with self-reflection is not contained within the self entirely. Internal evaluation is necessarily balanced with external evaluation and the balance of this is important, in counselling ideology the self is the locus of evaluation. However, the danger of counselling practices, such as supervisory space self-reflection is that supervision may be biased towards the supervisee, or counselling as a practice. This is particularly difficult in relation to IAPT, in which the profession of counselling appears to hold negative beliefs on the programme, and peer [external] evaluation including supervision, may encourage this position.[research letters, papers etc on IAPT and counselling]. Counsellors may therefore be vulnerable to self-censure in the process of	Use this code when participants reference any sense of negative internal evaluation, or self-censure relating to their association and/or experiences with IAPT, or for conforming to IAPT business or treatment requirements.	Do not use this code in cases where the counsellor expresses opinion that is related to external evaluators in relation to their association and/or experiences with IAPT, or for conforming to IAPT business or treatment requirements.	I felt really uncomfortable and bad that I've been, I don't know, pathetic just pops into my mind, that's not right, to actually do it, to feel so threatened that I was going to lose my job, which I loved, that I did something which totally went against my own beliefs,

		reflection and making sense of their IAPT experiences.			
CHANGE-ACTION	Attitude to change	Participants may express attitudes, or behaviours to change in relation to CPD, post IAPT. These may be positive or otherwise, and may affect motivation, and or ideology in respect of professional development. Action involves the most overt behavioural changes and requires considerable commitment of time and energy. Individuals are classified in the action stage if they have successfully altered the dysfunctional behaviour for a period from 1 day to 6 months.	Apply this code to all examples of text that can be identified as indicating action orientated behaviour or attitude to change in respect of, and in response to the IAPT business model, or	Do not use this code for data that can be identified as being change oriented but is not reflective of personal attitude, or behaviour to change, or when the aspect of the data indicates pre-contemplative, contemplative,	'I'm an optimist and that's how I am. I accept change, and just got on with studying CBT'

			treatment paradigm. This can be used when IAPT has been implemented in respect of an existing service, or when a counsellor joins an IAPT service, or when a counsellor leaves an IAPT service and works outside of IAPT.	preparatory, or maintenance orientated attitudes or behaviour.	

CHANGE-CONTEMPLATIVE	Attitude to change	Participants may express attitudes, or behaviours to change in relation to CPD, post IAPT. These may be positive or otherwise, and may affect motivation, and or ideology in respect of professional development. Contemplation is the stage in which participants are aware that a problem exists and are seriously thinking about overcoming it but have not yet made a commitment to act. Contemplators struggle with their positive evaluations of their dysfunctional behaviour and the amount of effort, energy, and loss it will cost to overcome it.	Apply this code to all examples of text that can be identified as indicating a contemplative orientated behaviour or attitude to change in respect of, and in response to the IAPT business model, or treatment paradigm. This can be used when IAPT has been implemented in respect of an existing service, or when a counsellor joins an IAPT service, or when a counsellor leaves an IAPT service and	Do not use this code for data that can be identified as being change oriented but is not reflective of personal attitude, or behaviour to change, or when the aspect of the data indicates pre-contemplative, preparatory, action, or maintenance orientated attitudes or behaviour.	

			works outside of IAPT.		
CHANGE-MAINTENANCE	Attitude to change	Participants may express attitudes, or behaviours to change in relation to CPD, post IAPT. These may be positive or otherwise, and may affect motivation, and or ideology in respect of professional development. Maintenance is the stage in which people work to prevent relapse and consolidate the gains attained during action. This stage extends from 6 months to an indeterminate period past the initial action. Remaining free of the problem and/or consistently engaging in a new incompatible behaviour for more than 6 months are the criteria for the maintenance stage.	Apply this code to all examples of text that can be identified as indicating maintenance orientated behaviour or attitude to change in respect of, and in response to the IAPT business model, or treatment	Do not use this code for data that can be identified as being change oriented but is not reflective of personal attitude, or behaviour to change, or when the aspect of the data indicates pre-contemplative, contemplative, preparatory, or	'I work hard to stay with the IPT approach, use the methods, rather than slip back into person-centred'

			paradigm. This can be used when IAPT has been implemented in respect of an existing service, or when a counsellor joins an IAPT service, or when a counsellor leaves an IAPT service and works outside of IAPT.	action orientated attitudes or behaviour.	

CHANGE-PRE-CONTEMPLATIVE	Attitude to change	Participants may express attitudes to change in relation to CPD, post IAPT. These may be positive or otherwise, and may affect motivation, and or ideology in respect of professional development. Precontemplation is the stage in which there is no intention to change behaviour in the near future. Most participants in this stage are unaware or under aware of their problems. Families, friends, neighbours, or employees, however, are often aware that the pre-contemplators suffer from the problems.	Apply this code to all examples of text that can be identified as indicating a pre-contemplative behaviour or attitude to change in respect of, and in response to the IAPT business model, or treatment paradigm. This can be used when IAPT has been implemented in respect of an existing service, or when a counsellor joins an IAPT service, or when a counsellor leaves an IAPT service and	Do not use this code for data that can be identified as being change oriented but is not reflective of personal attitude, or behaviour to change, or when the aspect of the data indicates contemplative, preparatory, action, or maintenance orientated attitudes or behaviour.	'they tried everything, and they failed because we mounted a very strong defence to it and they think they can get away with it basically'

			works outside of IAPT.		
CHANGE-PREPARATION	Attitude to change	Participants may express attitudes, or behaviours to change in relation to CPD, post IAPT. These may be positive or otherwise, and may affect motivation, and or ideology in respect of professional development. Preparation is the stage in which individuals are intending to take action in the next month and are reporting some small behavioural changes (‘‘baby steps’’). Although they have made some changes. Participants in the preparation stage have not yet reached a criterion for effective action. Action is the stage in which individuals modify their behaviour, experiences, and/or environment to overcome their problems.	Apply this code to all examples of text that can be identified as indicating preparatory behaviour or attitude to change in respect of, and in response to the IAPT business model, or treatment paradigm. This	Do not use this code for data that can be identified as being change oriented but is not reflective of personal attitude, or behaviour to change, or when the aspect of the data indicates pre-contemplative, contemplative, action, or	‘I bought myself loads of books, I spoke to other therapists who worked in a sort of solution focused approach, and it was basically trial and error’

			can be used when IAPT has been implemented in respect of an existing service, or when a counsellor joins an IAPT service, or when a counsellor leaves an IAPT service and works outside of IAPT.	maintenance orientated attitudes or behaviour.	
DEVELOPMENT-FACILITATED-FORMAL	Professional Development facilitated	Counsellors who have worked in IAPT may have been afforded the opportunity to engage in IAPT funded, formal, informal, and ad-hoc professional development i.e. training with and without final qualifications, CPD certified ad-hoc workshops and lectures, and references to professional development resulting from the experience of working in IAPT; such examples of professional development may not be immediately apparent, but accepted as development on reflection, rather than explicit examples such as workshops. For example, considering unwelcome working practices, that have enabled the counsellor to develop unexpected skills i.e. time management, as well as clinical skills. This code need not be	Apply this code to all references to IAPT funded, formal professional development i.e. training; informal opportunities such as service led workshops; references to informal professional	Do not use this code in cases were the counsellor has already owned any experience, or skills, or when the counsellor has self-funded, or undertaken the professional development in their own time, outside of the IAPT environment.	"So, what I learned in IAPT was how to work time limited."

		definitive in order to include broader examples of professional development.	development, such as experiences and opportunities facilitated because of working in IAPT. And to text which implies that the counsellor benfitted from working in IAPT, and IAPT working practices.		
DEVELOPMENT-FACILITATED-INFORMAL	Informal CPD	Counsellors who have worked in IAPT may have been afforded the opportunity to engage in IAPT funded, formal, informal, and ad-hoc professional development i.e. training with and without final qualifications, CPD certified ad-hoc workshops and lectures, and references to professional development resulting from the experience of working in IAPT; such examples of professional development may not be immediately apparent, but accepted as development on reflection, rather than explicit examples such as workshops. For example, considering unwelcome working practices, that have enabled the counsellor to develop unexpected skills i.e. time management, as well as clinical skills. This code need not be	Apply this code to all examples of text that refer to non-examined, or certified, accredited learning events of a , supervisory, self or peer directed, or informal nature.	Do not use this code for data that can be identified as reference to examples of CPD which is accredited, paid for, formally organised events for which certification, qualification, or examination are outcomes.	'we had a study group at lunchtimes … reading papers, discussing papers'

		definitive in order to include broader examples of professional development.			
DEVELOPMENT-IMPEDED	Professional Development held back	Counsellors who perceive that working in IAPT, or aspects of their experience of working in IAPT, has had a detrimental effect on their professional development. There is a belief that counsellors working in IAPT are not fully accepted, and that available professional development opportunities are not fully afforded to them, or appropriate to the counselling ideology. This can be of particular relevance to those working in fixed term, or zero hours contracts. Examples of this code can also be recognised informally, in respect of time, and demand pressure which is claimed to cognitively exhaust counsellors, and reduce opportunity for self-reflection, managerial, supervisory or peer support.	Apply this code to all references to counsellors' inability, or restriction to attend to practices that affect professional development, exclusion from formal, or informal training and CPD opportunities, inappropriate or unhelpful managerial supervision	Do not use this code when it is apparent that the impediments, or restrictions are counsellor based, for example if the counsellor chooses to decline opportunity on the basis of personal, practice-based, ideological, or perceived ethical difference.	"So, I was being held back from developing different understandings, or different ways of working that could have benefited me"

			practices, inappropriate or unhelpful clinical supervisory practices		
DRIVERS-AMBIVERSION	Ambivert drives for Professional development	Counsellors who exhibit personal, and self-interest drivers, along with selfless, altruistic, client-centred drivers, and IAPT treatment paradigm compliancy in choosing professional development opportunities.	Apply this code to all references to counsellors choosing professional development opportunities which are motivated by joint service user/client-centred drivers, IAPT treatment paradigm compliancy, and when they have a personal,	Do not use this code in cases where the counsellor has no commitment to conforming to the IAPT treatment paradigm.	"my overall aspect is if it helps the client, and it's appropriate, then I'm for it. I don't have a deliberate bias towards counselling, although I like counselling. And I don't have any deliberate value with CBT because I'm qualified in CBT"

			and/or self-interest in the training. When the counsellor demonstrates all aspects of self-interest, service user, and/or IAPT needs in CPD selection.		
DRIVERS-EXTROVERSION [EXOTERIC]	Extrovert drives for Professional development	Counsellors exhibiting IAPT service requirements as a decision-making priority related to professional development opportunities. Such a counsellor would typically be drawn to professional development opportunities because it would comply with the IAPT treatment paradigm.	Apply this code to all references to professional development choices which the counsellor has engaged with to comply with the IAPT treatment paradigm, irrespective of the counsellors' values, and beliefs	Do not use this code when counsellors have conflated motivations for training [Ambiversion] i.e. have undertaken IAPT approved training to conform to the IAPT treatment paradigm, but also have personal interest	"I recognised the benefits to clients of CBT, IAPT is CBT based and that's why I chose to train in that approach"

			regarding treatment approaches. When the counsellor demonstrates commitment to the IAPT treatment paradigm in CPD selection.	in training in the approach.	
DRIVERS-INTROVERSION [ESOTERIC]	Introvert drives for Professional Development	Counsellors exhibiting self-centred, or personal interest motivations in decision making related to professional development opportunities. Personal interest would be applicable for counsellors undertaking training to develop greater employment opportunity, or personal advantage. Counsellors are attracted to humanistic approaches to professional development, such as experiential group workshops, encounter groups, idiographic non-manualised therapy approaches that do not attract evidence-based status and are unacceptable to IAPT.	Apply this code to all references to training and CPD which the counsellor has chosen independently of IAPT or has been facilitated by IAPT, but which the counsellor is aware that the IAPT treatment paradigm will	Do not use this code when counsellors have shared motivations for training [Ambiversion] i.e. have undertaken IAPT approved training to validate themselves within the paradigm, but also have personal interest in the approach.	"The courses that I was going on, that interested me, didn't necessarily fit with the way I was working in IAPT."

			not approve its use on clients. When the counsellor demonstrates self-interest over service user, or IAPT in CPD selection.		
EMPLOYABILITY	Counsellors employability prospects	Counsellors have always recognised that there is work and unpaid work, and that paid work is at a premium for counsellors. IAPT created over 6000 jobs for psychological therapists but made a clear choice to avoid and make counsellors invisible, even preferring social workers, occupational therapists and nurses to counsellors. Employability is a key factor in professional development choice. How does IAPT affect that issue.	Use this code when data relates to counsellors employability or ability to monetise their skills. It may be in choice of PD opportunity or attitudes, ideology etc.	Do not use this code if data relates to non-paid work	"undertaking my IPT training made me more attractive to employers"

EMPOWERMENT	How counsellors are empowered or disempowered working in IAPT and how they get their needs met	In any working environment, or relationships the subject of power and control is worth considering. In IAPT, a tightly structured working environment, the subject of power and control in the working relationship between practitioners, and practitioners and management is also worthy of recognition. This code is about how counsellors get their needs met, and how management do likewise. what are the strategies employed by either in the 'games that are being played out' and how does that affect PD.	Use this code when data suggests that the counsellor or manager of the counsellor is responding to a situation and seeking to exercise control, empower themselves, or disempower others, either over a situation, or an individual. This code may parallel the BUSINESS code in some respects	Do not use this code if the data does not suggest that empowerment or disempowerment is not an issue the counsellor or the manager are not directly exercising control or seeking to exercise control over the individual.	I realised that the only way I could secure my job in IAPT was to train in IPT' ... 'My manager told me straight out, that I either see 8 clients a day or I would lose my job'
ENABLED	IAPT enables counsellors PD aspirations	In this study there are clear examples of IAPT enabling counsellors, perhaps not from a professional development perspective, but from an employability perspective, or to enable them to work part-time, or on the bank, or on fixed term contracts that suit their circumstances. This may occur whether the counsellor is IAPT trained or not. The difference might rest between a counsellor seeking opportunity, and one seeking skills and knowledge.	Use this code to capture content that describes counsellors using IAPT to enable their aspirations. a common example might	Do not use this code to describe content that describes counsellors facilitating professional development plans, such as training to be an	"but really my motivation (in applying for training) really wasn't to do CBT. It was more or less to get out of where I was"

			be to secure a permanent employment contract. It differs slightly from professional development, although it could be considered to be PD.	IPT therapist because that is what they want to become.	
ENGAGED-DISENGAGED [Rejection]	Counsellors feeling dis-engaged	Counsellor experiences of working in IAPT will differ in relation to many aspects of that working environment. This category is related to any aspect of the data which suggests that a participant was, or felt that they were excluded from, or not a part of the IAPT programme, whether that be in relation to the business, or treatment elements. The counsellor would have a sense of not belonging in the context of what is being expressed.	Use this code for examples of counsellors feeling that they do not belong or have isolated themselves, and do not want to contribute more, whether that is in relation to the team, colleagues, business or treatment aspects of IAPT life.	Do not use this code if the data is not clear about the sense of belonging, if any element of the data is uncertain	You know, it isn't all about the money, but what does it do to our own self-esteem if we're working hard and having good results and not…and actually better results than some of the paid workers and not being recognised financially for that?

ENGAGED [Acceptance]	Counsellors feeling engaged	Counsellor experiences of working in IAPT will differ in relation to many aspects of that working environment. This category is related to any aspect of the data which suggests that a participant was, or felt that they were a part of the IAPT programme, whether that be in relation to the business, or treatment elements. The counsellor would have a sense of belonging in the context of what is being expressed.	Use this code for examples of counsellors feeling that they belong, and are included, and that encourages them to contribute more, whether that is in relation to the team, colleagues, business or treatment aspects of IAPT life.	Do not use this code if the data is not clear about the sense of belonging, if any element of the data is uncertain.	Colleagues who liked me, and we got on really well, and they could see the benefit of what I did, and I was really interested, and could see the benefit of what they did. And we got on really well, you know?
EQUALITY	Counsellors being treated equitably	Counsellors in IAPT are often treated differently to other mental health practitioners, whilst being expected to undertake the same workload, case load, level of severity, and complexity of presentations. Counsellors generally work within IAPT at 'high intensity – step 3' yet are often graded and paid less than other high intensity practitioners. Counsellors being perceived as experiencing the Cinderella effect. However, this not always true depending on local circumstances, and counsellors may be treated equitably to their manualised colleagues.	Apply this code to all references to counsellors experiencing equal status and/or conditions as their manualised colleagues, irrespective of their status as	Do not use this code when the data indicates that counsellors have been treated with inequality, or advantageously in comparison with manualised colleagues.	"At step three, we all worked with the same client presentations, irrespective of modality "

			counsellors, ideological, or ethical stance, approach to treatment, or qualifications.		

ETHICAL	Perceived difference in ethical stance	Throughout the IAPT/Counselling narrative is the issue of ethics; what is ethical or not ethical in relation to treatment programs. Neither IAPT or Counselling appear to have adopted an ethical stance in relation to treatment (although BACP has a developed ethical code of professional conduct). It is difficult to define an ethical stance for either, though for the sake of this study the medicalised, manualised, command and control structure of IAPT is assumed to reflect utilitarianism - **Utilitarianism** is an ethical theory that determines right from wrong by focusing on outcomes. It is a form of consequentialism. Utilitarianism holds that the most ethical choice is the one that will produce the greatest good for the greatest number. It is the only moral framework that can be used to justify military force or war. It is also the most common approach to moral reasoning used in business because of the way in which it accounts for costs and benefits. Utilitarianism also has trouble accounting for values such as justice and individual rights (https://ethicsunwrapped.utexas.edu/glossary/utilitarianism). Counselling is assumed to reflect an ethical stance of Moral Absolutism - **Moral absolutism** asserts that there are certain universal moral principles by which all peoples' actions may be judged. It is a form of deontology. The challenge with moral absolutism, however, is that there will always be strong disagreements about which moral principles are correct and which are incorrect. For example, most people	Use this code when narrative refers explicitly or implicitly to issues that reflect a moral or ethical stance or issue in the participants perception.	Do not use this code when the issue is one perceived by the analyst, from the analysts own worldview (this may prove difficult but err on the side of assumption).	"I don't think you can treat everyone as a product, people are different and have different needs"

		around the world probably accept the idea that we should treat others as we wish to be treated ourselves. But beyond that, people from different countries (or ideologies) likely hold varying views about everything from the morality of abortion and capital punishment to nepotism and bribery - or definitions of, and treatment of mental distress - (https://ethicsunwrapped.utexas.edu/glossary/moral-absolutism).			

EXPLOITATION	The exploitation of counsellors	Taking advantage of counsellors through employment practices, such as fixed term, zero hours contracts, and the managerial use of the phenomena known as psychological contracting to encourage informal expectation of future benefits for current support. Treating counsellors on contracts – other than permanent contracts – as second-rate workers, who are not afforded full employment benefit, but expected to work to the same standards, and often not afforded opportunities for professional development that permanent contract holding staff are offered. Using counsellors (despite IAPT and NICE guidance not supporting counselling) to meet IAPT contractual obligations, without permanent employment are all examples of exploitative treatment.	Apply this code to all references by counsellors to managerial relationships and behaviours in which the counsellor is encouraged or required to meet the service needs, but the counsellors' needs are not met. Counsellors being manipulated or treated unfairly in order that the service management benefits from their work.	Do not use this code for reference to examples were the counsellor and management have explicitly agreed a transaction, and the agreement has been honoured. When counsellors exploit the IAPT programme, or the service that they are employed in.	"I saw that I wasn't going anywhere. This promise of a band seven job, possibly band eight job, which my manager actually at appraisal would talk to me about, never was going to materialise"

FRUSTRATION-AGGRESSION	Counsellors frustrated and showing aggression towards IAPT	Brown (1954) Describes the concept and negative consequences of frustration in detail, whilst defining the phenomenon as "When a person is motivated towards a goal and something interferes with his progress towards it, he is said to be frustrated" (p. 245). Brown posits that frustration can lead to four types of behaviours characterised as: AGGRESSION, commonly recognisable as excessive criticism of management, malicious gossip, voicing of superficial grievances, militancy, absenteeism, and neurosis. In IAPT terms, the counsellors in this study, and the literature, report only non-physical aggression, mostly projected towards persons, and objects such as IAPT itself in the form of opinion in verbal and written form (see BACP TT and Rizq etc);	Use this code when the data suggests the counsellors professional development aspirations are frustrated by IAPT, and the actions are indicative of aggression as in the full definition. This is not a value statement on the counsellor, but an observation to help understand the effect on counsellors professional development	Do not use this code if the data is reflecting behaviours not relating to a frustration of the counsellors professional development i.e. another's experience or a personal issue.	"if people cancelled two sessions you had to discharge them. So, I used to not put all the appointments on the system"

FRUSTRATION-FIXATION	Counsellors frustrated and showing fixated tendencies towards IAPT	Brown (1954) Describes the concept and negative consequences of frustration in detail, whilst defining the phenomenon as "When a person is motivated towards a goal and something interferes with his progress towards it, he is said to be frustrated" (p. 245). Brown posits that frustration can lead to four types of behaviours characterised as: FIXATION, an inability to accept change, blind or stubborn refusal to accept new facts, being compelled to repeat behaviours, which prevents the use of new more effective ones. Which in IAPT terms may be present in counsellor's refusal, or inability to develop outside of the idiographic ideologies of Rogerian person-centred theory or retraining in IAPT specific modalities such as Interpersonal Psychotherapy (IPT), or even IAPT Cognitive Behavioural Therapy (CBT)	Use this code when the data suggests the counsellors professional development aspirations are frustrated by IAPT, and the actions are indicative of fixation as in the full definition. This is not a value statement on the counsellor, but an observation to help understand the effect on counsellors professional development	Do not use this code if the data is reflecting behaviours not relating to a frustration of the counsellors professional development i.e. another's experience or a personal issue.	"I turned down IPT training because it just seems wrong to diagnose people as mentally ill"

FRUSTRATION-REGRESSION	Counsellors frustrated and showing regressive tendencies towards IAPT	Brown (1954) Describes the concept and negative consequences of frustration in detail, whilst defining the phenomenon as "When a person is motivated towards a goal and something interferes with his progress towards it, he is said to be frustrated" (p. 245). Brown posits that frustration can lead to four types of behaviours characterised as: REGRESSION, characterised as being more suggestible, prone to confirmational bias, with a yearning for past conditions i.e. the good old days. In relation to this study, counsellors demonstrate fixed opinions on IAPT, negative comparisons with previous counselling service, a sense of loss, coupled with disempowerment. In some cases, manifesting itself in internalised pain, and with a suggestion of resultant negative effect on health and wellbeing	Use this code when the data suggests the counsellors professional development aspirations are frustrated by IAPT, and the actions are indicative of regression as in the full definition. This is not a value statement on the counsellor, but an observation to help understand the effect on counsellors professional development	Do not use this code if the data is reflecting behaviours not relating to a frustration of the counsellors professional development i.e. another's experience or a personal issue.	"it was so much better before IAPT, we all got on really well, and everyone agrees that manualised therapies are so unethical"

FRUSTRATION-RESIGNATION	Counsellors frustrated and showing resignation to IAPT demands	Brown (1954) Describes the concept and negative consequences of frustration in detail, whilst defining the phenomenon as "When a person is motivated towards a goal and something interferes with his progress towards it, he is said to be frustrated" (p. 245). Brown posits that frustration can lead to four types of behaviours characterised as: RESIGNATION, which is observable by apathy relating to change, particularly to new systems. Resignation would encompass the population of this study on account of having left IAPT, and sadly in all cases with unmet expectation as a dominating feature.	Use this code when the data suggests the counsellors professional development aspirations are frustrated by IAPT, and the actions are indicative of resignation as in the full definition. This is not a value statement on the counsellor, but an observation to help understand the effect on counsellors professional development	Do not use this code if the data is reflecting behaviours not relating to a frustration of the counsellors professional development i.e. another's experience or a personal issue.	"After a while i just gave up the ghost and just did whatever was asked of me, for an easy life"
GENERIC	Generic Unique Code	There may be examples of text that might be of some importance, but which cannot yet be evaluated for fit with the bigger analytic picture. Such text should be considered for tagging, and consideration later, when the analytical picture is broader and more detailed.	Apply this code to all examples of text that might be of some importance, but which cannot yet be	Do not use this code for data that can be identified as being within the scope of identified codes, or for data which	'As a personality, I think IAPT suited me in the way that, for instance, I started using psychological

			evaluated for fit with the bigger analytic picture.	suggests the construction of a new code.	measures which I hadn't learned at university’
GROWTH	Counsellors experiencing professional growth	Counsellors who have worked in IAPT will often recognise aspects of their service as enabling professional growth, for example gaining a better understanding of psychiatric disorders etc. The experience of IAPT service is not always negative, in fact it is almost predominantly mixed in its qualities. It is not often that a counsellor will dismiss all of their IAPT experience as being negative. It may also be that time away from IAPT may enable the counsellor to see growth were they could not previously, perhaps closer to their IAPT service	Use this code when data recognises a professional growth as a result of working in IAPT, no matter how subtle or unacknowledged that may be. Some counsellors may not recognise or acknowledge aspects of their growth, so the coder may attribute growth on their behalf.	Do not use this code for data that is indicative of growth that is non-attributable to IAPT i.e. if the counsellor attended self-selected and funded CPD or training with no link to IAPT whilst in IAPT service i.e. sand play therapy workshop but could not use that in IAPT mode.	"And IAPT enabled me to see a possible way of doing that and also gave me the courage and the wherewithal if you like to realise that I could do that. That is something that I can do [operate privately]. That's within my capabilities"

HEALTH	Effect on Counsellors health [Emotional & physical]	In any workplace, the issue of health and safety is a consideration. However, in IAPT counsellors may, particularly due to ideological difference, experience enhanced levels of emotional stressors. This can then contribute to physical health matters and result in ill health of both the emotional and physical. likewise, physical health vulnerabilities may, due to IAPT specific conditions i.e. peripatetic working practices etc., contribute to emotional health stressors. the two may be singular, but likely co-morbid.	Apply this code to data that suggests that counsellors have experienced ill health, of an emotional and/or physical i.e. co-morbidity as a result of working in IAPT. Include ill health which may have been pre-existing and controlled, but which has been exacerbated as a result of IAPT working.	Do not apply this code if the ill health is a pre-existing condition and has not been exacerbated as a result of working in IAPT.	'… and doing the IPT really contributed to the next health problem that I ended up getting, which yeah, I'm not very happy about'

IAPT-BLAME	Accusing IAPT as an entity	Participants may express thoughts and emotions in relation to IAPT as an entity being responsible for negative experiences, such as lack of support, progression, professional development, personal distress. This code can be broadly interpreted and should be inclusive. Participants may project responsibility or blame onto IAPT, as opposed to individuals such as managers, colleagues, or leaders of the broader IAPT organisation in NHS England. IAPT can often be referred to 'as if' it exists, when it is a programme that is interpreted, and implemented in various ways by many contract holders.	Use this code when participants attribute blame, responsibility, or project negative thoughts and/or emotion to IAPT as an entity.	Do not use this code for data that represents participants identifying individuals as having responsibility or blame for the participants negative experience. Or when others project their negative attitudes towards IAPT onto the participant	'IAPT really held me back, not supporting my personal development as a counsellor'
IAPT-PRAISE	Praising IAPT as an entity	Participants may express thoughts and emotions in relation to IAPT as an entity being responsible for positive experiences, such as support, progression, professional development, personal achievement. This code can be broadly interpreted and should be inclusive. Participants may express positive feedback on IAPT, as opposed to individuals such as managers, colleagues, or leaders of the broader IAPT organisation in NHS England. IAPT can often be referred to 'as if' it exists, when it is a programme that is interpreted, and implemented in various ways by many contract holders.	Use this code when participants express positive thoughts or attribute responsibility for progression or growth to IAPT as an entity.	Do not use this code for data that represents participants identifying individuals as having responsibility for the participants positive experience. Or when others project their positive attitudes	"I think IAPT helped me to progress from a position of being a new counsellor with little knowledge or skills in real world stuff, to the counsellor I am today, empowered, employable,

				towards IAPT onto the participant	organised, and business like"
IDEOLOGY-DIFFERENCE	Counsellors struggling or conflicted around ideological difference	Counsellors are generally trained in, and/or attracted to counselling as a result of its idiographic ideological stance, and often remain attached to that ideological stance. It is questionable whether, and to what degree counsellors recognise this aspect of their work for what it is, and even whether they understand the theoretical and pragmatic value it has in relation to their profession practice, and development. There are a number of ideological stances highlighted in this study: Idiographic; referring to those therapy approaches which highlight the unique elements of the individual, who is seen as unique, with unique life experiences, offering values, beliefs, and qualities that differentiate the person from other individuals. Focus is on, and valuing of the client's experience, and story, and how that informs the clients values, beliefs, and behaviours. An idiographic approach would be one that values growth, and development of self, rather than a fixed, or dogmatic belief in human nature. The difference in ideological stance bewteen counselling and that adopted by IAPT	Use this code when the data relates to aspects of ideology, and ideological stance either in treatment, relationships, business or treatment aspects.	Do not use this code if the data refers to	Some of the other things that I sort of noticed early days as well, was just an awareness of people from other backgrounds that had come into IAPT. There seemed to be perceptions in the way that it was…it was almost feeling like a bit robotic in the way that ... therapy could be offered

		[Nomothetic] are opposing and therefore can create issues for counsellors in relation to practice, and therefore professional development.			

IDEOLOGY-IDIOGRAPHIC	Non-manualised counsellors/counselling	The term refers to those therapy approaches which highlight the unique elements of the individual, who is seen as unique with a unique life history, and properties setting him/her apart from other individuals. Focus is on and valuing of the client's history and biography, and how that informs the clients values, beliefs, and outlook. An idiographic approach would be one that values growth and development of self, rather than a fixed, or dogmatic belief in human nature. refers to those methods which highlight the unique elements of the individual phenomenon—the historically particular—as in much of history and biography. The contrast is with the nomothetic, which seeks to provide more general law-like statements about social life, usually by emulating the logic and methodology of the natural sciences. The distinction hails from the German philosopher Wilhelm Windelband and provoked an acrimonious debate (the so-called Methodenstreit) in late 19th-century Germany and Austria, between proponents of generalizing and individualizing approaches to the social, historical, and cultural sciences. Many of Max Weber's methodological writings are directed towards this debate, notably his theory of concept formation and ideal types, although the issues have also been popularized via the psychological writings of Gordon Allport. [Also Transference and ''The Rebbe'' Idiographic and Nomothetic Factors in the Psychoanalysis of Lubavitch Chassidim. Martin A. Schulman & Ricki S. Kaplan.	Use this code for references to examples were the counsellor is describing non-manualised therapeutic approaches which highlight the unique elements of the individual, who is seen as different to others, with a unique life history, and properties setting him/her apart from other individuals.	Do not use this code for references to examples were the counsellor is describing therapeutic approaches which are identifiable by the implementation of manualised approaches to treatment, and/or the treatment of the diagnosis over the individual, or examples of pluralistic	'… I think a lot of people who do counselling want to work outside the medical model because of that, because labels and things can be very reductive'

		Published online: 4 July 2013 Springer Science Business Media New York 2013]. The terms idiographic and nomothetic were introduced into the social sciences by Gordon Allport (1937) in developing criteria for a science of person ology. Idiographic describes the study of the individual, seen as a unique agent having a unique life history, with properties that set him or her apart from others. Nomothetic describes the study of classes, cohorts or groups of individuals. This paper focuses on the need to distinguish individual beliefs from those same beliefs which are integral to that person's community			

IDEOLOGY-NOMOTHETIC	Manualised counsellors/counselling	The nomothetic seeks to provide more general law-like statements about people, their values, beliefs, and behaviour. The nomothetic describes the study of classes or cohorts of individuals, identifying and grouping corresponding personality traits and behaviours, that inform the therapeutic approach. Nomothetic approaches in IAPT are identifiable by the implementation of manualised approaches to treatment, and the treatment of the diagnosis over the individual.	Apply this code to all references to examples were the counsellor is describing therapeutic approaches which are identifiable by the implementation of manualised approaches to treatment, and/or the treatment of the diagnosis over the individual.	Do not use this code for references to examples were the counsellor is describing non-manualised therapeutic approaches which highlight the unique elements of the individual, who is seen as different to others, with a unique life history, and properties setting him/her apart from other individuals, or examples of pluralistic	'CBT can be shown to be more evidence-based … than counselling because it can be measured, in the changes in terms of scores, it's very much of a homework-based therapy'

IDEOLOGY-PLURALISTIC	Inclusive approaches	Pluralistic approaches assume that no one therapeutic approach has the monopoly on understanding the causes of distress or on the most helpful therapeutic responses. Instead, it suggests that different clients are likely to want, and benefit from different things in therapy. Hence, it suggests that therapists should be open to respecting understandings and practices from across the counselling and psychotherapy spectrum. A pluralistic approach emphasises shared decision making and meta-therapeutic communication: talking to clients about the process of therapy itself, including what they want from it and how they would like to try and get there. Pluralism can be a way of thinking about therapy, or it can be a specific practice in which the therapist draws on a range of different understandings and methods.	Apply this code to all references to examples were the counsellor is describing therapeutic approaches which are identifiable by the qualities of including both idiographic and nomothetic approaches, were the client is engaged in the theoretical, and ideological knowledge base of the available approach, and is collaboratively involved in their treatment choices.	Do not use this code for references to examples were the counsellor is describing idiographic, or nomothetic approaches to therapy.	'on the whole, I was trying to look at what the individual needed, there was quite a lot of psycho-education, so I was doing more of that'

INEQUITY	Counsellors being treated unfairly	Counsellors in IAPT are often treated differently to other mental health practitioners, whilst being expected to undertake the same workload, case load, level of severity, and complexity of presentations. Counsellors generally work within IAPT at 'high intensity – step 3' yet are often graded and paid less than other high intensity practitioners. Counsellors being perceived as experiencing the Cinderella effect.	Apply this code to all references to counsellors experiencing inequality based on their status as counsellors, ideological, or ethical stance, approach to treatment, qualifications, decisions made by service management, which negatively differentiate counsellors from other practitioners working at the same intensity.	Do not use this code when it is apparent that counsellors choose to decline opportunities, that have been offered to other practitioners of different grade or modality, on the basis of personal, practice-based, ideological, or perceived ethical difference.	"It wasn't available to me. It was really quite…I was an outsider, really"

INFORMATICS	Impact of data on Professional Development	Collection, analysis, and dissemination of data in the IAPT programme is a central theme of both business and treatment models. Participants may express thoughts and feelings about the informatics element of IAPT, and the effect that this may have had in respect of professional development. the effects may be implicit or explicit, the participant may or may not be aware if the connection between informatics and their professional development.	Use this code when participants refer to informatics, data collection, management, and dissemination.	Do not use this code for data that is not related to the IAPT programme informatics strategy.	
LAUGHTER	Counsellors laughing in interview	The presence of laughter in the narrative is regular, I am unclear as to what this conveys or represents, so I have created this code to register the laughter when it is present for later consideration. Laughter can convey humour, irony, frustration, even anger, and it may be that the presence of laughter represents a code that is important to the professional development of the counsellor in the IAPT environment.	Use this code whenever the participant laughs or giggles, or chuckles, or any other description for the presence of such expression, irrespective of the motive, or perception of the laughter.	Do not use this code if laughter is not present, but the participant makes narrative reflections, such as 'I laugh about it now' but laughter is not present.	"But they didn't necessarily want the counsellors, (Chuckles) so I think that's where it came from (the antagonism)"

LEAVING	Counsellors reasons for leaving IAPT	Counsellors may have varied factors that contributed to their reasons for leaving, and these may be positive or negative. It is important to collect and analyse the reasons for leaving IAPT to help contextualise the effect on professional development	Use this code for data that describes counsellors reasons for leaving IAPT. Include such data even if the counsellor had no influence in the decision to leave i.e. contract terminated.	Do not use this code if the narrative is about considering leaving IAPT, as the counsellor may not continue on to leave for those decisions being outlined, as time and circumstances may have changed at the time of leaving.	"I was promised a permanent contract for two years and I realised it was never going to happen, so I got out"
MANAGEMENT	The impact of management on counsellors CPD	Each IAPT service is separate from the other contracted IAPT services, and whilst the strategy is to have replicability it is often not happening. Consideration must be given to the effect of divers management on counsellors professional development	Use this code when data suggests a managerial context to the issue described in the data	Do not use this code for data referencing the counsellors self-management	"my manager ... was an ex nurse ... she was a bit of a slave driver and she saw that working with a maximum of eight patients a day really wasn't good enough"

MANUALISED	IAPT manualised therapies	Participants may express thoughts, feelings or references to IAPT manualised therapies. Such therapies are distinct from ideographic and nomothetic therapies per se, as they have been developed explicitly for use in IAPT. Examples would be PCE CfD, DiT, IPT, IAPT CBT, CCfD, and PWP training	Use this code when participants reference any of the aforementioned treatment models	Do not use this code for references to non-IAPT modalities	So, I was offered PWP training, and refused it'
MONETISE	Counsellors ability to monetise skills and experience	Whilst some psychological therapists who self-identify as counsellors are content to work voluntarily, there are others who wish to monetise their skills and experience. This might be using short-term contracts, permanent contracts, zero hours contracts etc. There is a need to recognise those who work in IAPT with the express purpose of receiving payment. This is also reflected in those counsellors who leave the NHS and seek work for payment elsewhere. Capturing this motivation is important and might demonstrate something of value to this research.	Use this code when participants demonstrate a desire to receive payment either in the short term or long term, under any mean of contract that will supply. This code will reflect counsellor monetising their skills and experience	Do not use this code when participants demonstrate using their skills voluntarily without payment, or who do not seek to monetise their skills and experience	I'm thriving and that I've made success in my own micro business, and I'm making a living'

POST-IAPT	Counsellors experience post-IAPT	This study is about the effect on counsellors professional development having worked in IAPT services. The purpose of this code is to capture the post-IAPT experience, whether IAPT changes the professional development in terms of ideology, ontology, epistemology, practice, both clinical and administrative.	Use this code when data relates to the counsellors post-IAPT experiences, values, beliefs etc.	Do not use this code to capture counsellors aspiration pre-IAPT, only those experiences, values, beliefs etc. that have occurred	I've done well out of IAPT, I have a waiting list now for my private practice"
PRE-IAPT	Counsellors experience Pre-IAPT	This study is about the effect on counsellors professional development having worked in IAPT services. The purpose of this code is to capture the pre-IAPT experience. This will provide an indication as to whether IAPT changes the professional development in terms of ideology, ontology, epistemology, practice, both clinical and administrative.	Use this code when data relates to the counsellors pre-IAPT experiences, values, beliefs etc.	Do not use this code to capture counsellors aspiration post-IAPT, only those experiences, values, beliefs etc. that have occurred	Prior to IAPT my attitude to CPD was based on what was of interest'
PSYCHOLOGICAL CONTRACTING	How counsellors can be controlled by management	Within the management of IAPT there appears to be a behaviour of managers to always offer jobs tomorrow, either explicitly or implicitly. This phenomena is known as psychological contracting and refers to a process by which managers can keep people onside by either implying or disclosing the opportunity for permanent contracts, or allowing a keen and hopeful volunteer, or temporary contract holder to believe that permanent posts are a future prize. The process can work in reverse also, whereby the worker can assume that future opportunity will present itself, and the manager does not dissuade the worker of that notion, but	Use this code when participants disclose that they were lead to believe or were informed by managers that permanent contracts for counsellors, or training, or other benefits	Do not use this code if the manager had not made or implied such benefits, or were explicit in stating that counsellors work, or benefits were not an option, or the counsellor had assumed without cause that	She [the manager]had promised me that I would be getting a paid job at some point. They were looking at the idea of taking counsellors on alongside the psychological well-being practitioners

		uses it encourage the worker to continue to commit.	were future options.	benefits would be available.	
QUALIFICATION	Formal education undertaken	In England, Northern Ireland and Wales, the levels are contained within the Regulated Qualifications Framework (RQF), which superseded the Qualifications and Credit Framework from 1 October 2015. There are nine levels of difficulty in the framework, from entry level (which is sub-divided into 3) to level 8. Counsellors who refer to formal educational courses, which can be supplied by IAPT, or other educational providers such as an NHS trust, or an external provider such as a University or Further Education College, or a sole trader advertising in professional journals. To fit this category, the educational event should provide a level within the nine levels of difficulty above. This code can include reference to IAPT qualification requirements also.	Apply this code to all references to examples were the counsellor is describing education, which is presented as formal, rather than informal, and is qualified within the RQF. Also, consider the use of this code for references to IAPT	Do not use this code for references to examples were the counsellor is describing education that is peer arranged, provided, or not validated by the RQF.	'I've trained up to Master of Science level in counselling psychology. My undergraduate was in health and social care' AND 'IAPT didn't want to employ me because I didn't have the qualifications they wanted'

			qualification requirements.		
REFLEXIVITY	Counsellors reflexive qualities	Counsellors are expected to be reflexive in personal and professional perspectives. However, the term can be misunderstood, and used by some interchangeably. Taking from Gubi [Thesis]. Bolton (2014) states that 'reflection' is about bringing experiences into focus by using the 'why' question from as many angles as possible, whereas 'reflexive' is more about questioning our own attitudes, assumptions, prejudices, and habitual actions, and how congruent our actions are with our espoused values and theories (p. 7). In this regard counsellors demonstrating reflexive qualities would be considering how IAPT had contributed or taken away from their professional development from an internal evaluative perspective, rather than focussing on the rights and wrongs of how they were being treated i.e. commenting or questioning why IAPT had affected their PD [or even themselves] from an external evaluative perspective.	Use this code when narrative demonstrates a counsellor questioning their own attitudes, assumptions, prejudices, and habitual actions, and how congruent their actions are with their espoused values and theories relating to IAPT and their	Do not use this code when the counsellor is questioning their experiences in IAPT from the perspective of why they were treated that way; when the locus of evaluation is external rather than internal.	

			PD. When the locus of evaluation is internal rather than external.		
RESENTMENT	Counsellors experiencing resentment towards IAPT, Managers and peers	As a result of working in IAPT some counsellors experience feelings of resentment to IAPT, their peers and colleagues, and management. Recognising this in counsellors can be important with regards to what decisions they might make in relation to PD. Such feelings can hold back professional development, or even generate motivation to change.	Use this code when data suggests that the counsellor is experiencing resentment towards colleagues [manualised or counsellors] management, or IAPT as an entity, as a result of their treatment	Do not use this code if the resentment is personally based, as in a personal dispute associated to IAPT as a business model or treatment paradigm.	I did feel a bit bitter for a while, yeah. Because life was hard at that time and, you know, I was doing the old single parent thing and, you know, trying to get paid work and working really hard

			whilst serving in IAPT. Either at the time, or on later reflection.		
RESILIENCE	Counsellors demonstrating resilience	Working in IAPT is generally accepted to be a pressured work environment, targets are tough, the clinical work demanding, and the business model parameters change regularly, which can cause the treatment models to flex in response i.e. shortening amount of sessions to reduce wait times. it is important to recognise counsellors resilience or lack of resilience when working in IAPT.	Use this code when the data suggests that counsellors have demonstrated resilience or a lack of resilience in circumstances related to working in IAPT. These can be business, treatment and relationally related, be open with your	Do not use this code when references are made to other persons, who are not the participant.	I'm quite a resilient person, I think. And I was able to use that to push myself

			interpretations on this code.		
RITUALS	Counsellors regular coping strategies	Counsellors in IAPT may develop behaviours, or strategies to help manage the impact of the treatment and/or Business models. These can be observed as ritualistic, for example specific counsellor meetings, either formal and approved, or informal peer get togethers in which processes play out that help to express, and or manage the issues of working in IAPT. these rituals may have a negative, or positive affect on the counsellors professional development. This code should be indicative of a pattern. This code should be indicative of a pattern.	Use this code when data highlights behaviours or strategies that suggest regular, or ritualistic aspects of counsellors IAPT life designed to be an outlet for expression, and/or management of the pressures and idiosyncrasies of IAPT working.	Do not use this code if the data is a 'one off' example of behaviour or a meeting.	In the mornings when I was going in to do my notes, I'd find young colleagues coming in and needing a chat and a coffee because they were dealing with 80 to 100 cases'

SECTARIANISM	The presence of bigotry, discrimination, or hatred arising from attaching relations of inferiority and superiority to differences between ideologies	Applying the word sectarianism, and what it conjures up in a modern day cultural, ethnic, or religious context to IAPT may seem on first consideration to be extreme. As a word, sectarianism is commonly used to describe extremism; this code seeks to employ the word in a descriptive manner to the experience of counsellors, and counselling in IAPT. For example, **' The determination of actions, attitudes and practices by beliefs about ideological differences, which results in their being invoked as the boundary marker to represent social stratification and conflict'** within the IAPT programme would be a use of this code to explore how that process might affect professional development.	Use this code when the data suggests that counsellors are adopting a position in IAPT, towards other groups; and when other groups are adopting a position in IAPT towards counsellors or counselling, that is indicative of actions, attitudes and practices by beliefs about ideological differences, which results in their being invoked as the boundary marker to represent social stratification and conflict between	Do not use this code if the data suggests attitudes and practices by beliefs about ideological differences, which results in their being invoked as the boundary marker to represent social stratification and conflict between counsellors and other groups outside of IAPT.	You know, we need to put forward the fact that we [counsellors] offer something that's very valuable ... Just because certain people … individuals within the IAPT didn't recognise me, doesn't mean that, you know, I can't do it [deliver therapeutically].

			counsellors and other groups in IAPT.		
SUPERVISION	Counsellors use of supervision	Supervision is defined by BACP under the Ethical Framework for the counselling professions 2018 point 60 as: [Supervision within the counselling professions] Supervision is essential to how practitioners sustain good practice throughout their working life. Supervision provides practitioners with regular and ongoing opportunities to reflect in depth about all aspects of their practice in order to work as effectively, safely and ethically as possible. Supervision also sustains the personal resourcefulness required to undertake the work [https://www.bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions/]	Use this code when participants make reference to supervision in order to capture how supervision might contribute, positively or otherwise, to professional development.	Do not use this code if participants are referring to ad-hoc conversations with colleagues or managers that result in clarity of professional issues but are not explicitly supervisory in nature.	" ... for the charity I had a separate supervisor. And in both of those (IAPT and the charity), I talked about how; knowing how I trained and what I wanted to be and how I wanted to be,

					and the pressures of working in IAPT and being a bit more short-term meant that, at times, I was like, I don't know what sort of counsellor I am"
TOLERANCE	Counsellors demonstrating tolerance towards IAPT generally, and IAPT management process	Given the difference in ideologies between counselling and manualised medicalised approaches to psychological therapy, there will be a degree of friction in any business model that adopts a positivistic, or generalised treatment paradigm. Coupled with a tightly regulated business model, there is scope for conflict. Counsellors working in IAPT have shown a degree of tolerance for these differences in ideology.	Use this code when data indicates tolerance for IAPT of IAPT business practices from counsellors	Do not use this code when data indicates that counsellors may have been coerced, or bullied into accepting IAPT ideologies, or IAPT business practices.	I understand what IAPT is trying to achieve, I just find it personally difficult to believe in IAPT

TOLERANCE-INTOLERANCE	Counsellors demonstrating Intolerance towards IAPT generally, and IAPT management process	Given the difference in ideologies between counselling and manualised medicalised approaches to psychological therapy, there will be a degree of friction in any business model that adopts a positivistic, or generalised treatment paradigm. Coupled with a tightly regulated business model, there is scope for conflict. Counsellors working in IAPT may show a degree of intolerance for these differences in ideology and practice.	Use this code when data indicates intolerance for IAPT or IAPT business practices from counsellors	Do not use this code when data indicates that counsellors may have been coerced, or bullied into accepting IAPT ideologies, or IAPT business practices.	I kept constantly trying as hard as I possibly could to keep doing all the things that I knew they [the clients] actually needed, which is person centred,

TREATMENT	IAPT as a Treatment Paradigm	IAPT as seen through the lens of its treatment paradigm, a clinical ideology which is medicalised in nature, and positivist in its evidence-based stance. There is an assumption that IAPT treatment activity will conform to this paradigm, as laid down by the IAPT Implementation Plan (2008).	Apply this code to all references to IAPT approved or non-approved clinical, medical, training, treatment experiences, and practices described. This would include references to psychometric measures, treatment modalities, session length, and all instances describing therapeutic and/or administrative activity which is therapeutically employed to contribute to service user recovery from	Do not use this code for reference to activity such as administrative functions, such as data collection that are not explicitly intended to be therapeutic, and/or to contribute to service user recovery from mental ill-health; practitioner involvement in non-IAPT professional development activity.	"For instance, I started using psychological measures which I hadn't learned at University - The GAD7, the PHQ9 for depression"

			mental ill-health. Counsellors professional development will be affected by the IAPT treatment paradigm, either explicitly or implicitly and this code is intended to capture those examples.		

UNCLEAR	Unclear data	It is a rare interview where every statement contains useful information. Where significant portions of text are not fully interpretable or are meandering, and of questionable value, it may be worthwhile to capture those data as distinct segments and label them as unclear data. When you have gained a more nuanced understanding of the way participants talk about the research topic, what appeared to be poor data may later make sense.	Apply this code to all significant portions of text that are not fully interpretable or are meandering, and of questionable value. Consider capturing those data as distinct segments and label them as unclear data.	Do not use this code for data that can be identified as being within the scope of identified codes, or for data which suggests the construction of a new code.	'Well, we did this exercise one day at university. And on the master's course I was on there were overseas students from Greece, from all different parts of the world, but they were obviously predominantly, they were British students, but there were probably 60 of us divided into three groups'

WORKLOAD	IAPT practitioner workload	Participants report the effect of carrying large and/or demanding workloads. Commonly high intensity practitioners will be expected to book 6 clients per day, in a 7.5 hour working day. Some IAPT services deviate from this number either less or more, and at times will change the amount of sessions available to a practitioner to meet other conflicting business and/or treatment targets.	Use this code when participants express comments on their own or other workloads, caseloads, and/or the effect that it is having on themselves, either positively or negatively. Or when a participant comments on their collective workload if carrying such outside of IAPT i.e. in private practice.	Do not use this code for comments on non-IAPT workloads if participant is commenting on workloads which are not concurrent to the period being discussed, or if they do not relate to participants IAPT experience.	I'd find young colleagues coming in and needing a chat and a coffee because they were dealing with 80 to 100 cases…that was their case load, a rolling caseload which was obviously far too much'